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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Retirement Residence	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a resident's privacy and dignity were maintained for one of two residents. The deficient practice compromised Resident (R) 36's privacy and dignity.Findings Include:Review of the facility reported incident (Intake #2636069) received on 10/04/25, documented that a Certified Nurse Aide (CNA) reported a video was taken on 09/30/25 during evening shift using the facility's cell phone. The video depicted R36 during peri-care with a heavily soiled incontinence brief.R36 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, dysphagia, obstructive sleep apnea, hemiplegia/hemiparesis due to cerebral infarction, Diabetes type 2, mild cognitive impairment, and epilepsy.Review of R36's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/07/25, documented in Section H (Bladder and Bowel) that R36 is always incontinent of urine. In Section GG (Functional Abilities and Goals) documented R36 was dependent on staff for toileting hygiene, including perineal hygiene and adjusting clothes before and after voiding.Review of the facility's INVESTIGATIVE REPORT FOLLOWING ADVERSE EVENT for the incident on 09/30/25 regarding R36, documented the event as Possible Neglect & Privacy Breach. The report documented A recorded video was taken of resident's buttock with saturated urine by License Staff. Video was then shared to other staff members during shift-to-shift report for the purposes of reminding staff to change resident to prevent skin breakdown.On 11/19/25 at 08:35 AM, an interview was conducted with R36. R36 reported she was unaware that a video was taken while she was receiving personal care, stating, why would they do it? She stated she would not be okay with any picture or video being taken of her and reported that if asked for consent, she would object to it because there is no reason to do it.On 11/20/25 at 11:15 AM, an interview was conducted with the Administrator. During the facility's investigation, Administrator reported they learned there was tension between day and evening shift staff, and the evening staff were frustrated with the resident's condition. The Administrator confirmed the video contained an image of R36's uncovered buttocks, a urine saturated incontinence brief, and pad, and was shown during shift-to-shift report. On 11/20/25 at 11:15 AM, an interview was conducted with CNA 31. CNA31 stated a video was shown during shift report depicting a resident with urine leaking from the incontinence brief. CNA31 confirmed the video included the resident's buttocks and stated the video was disturbing because staff should not be recording residents, and it may be a violation.On 11/20/25 at 12:13 PM, a telephone interview was conducted with Registered Nurse (RN) 33. RN33 stated on 09/30/25 at approximately 07:00 PM, a CNA reported that R36's clothes, incontinence brief, and pad were soiled. RN33 stated the resident verbalized she had only been changed once during the day shift. RN33 admitted she recorded a video of the urine saturation using the facility's cell phone to remind everybody to change the resident more frequently because the wound on her butt was not healing and to prevent future skin breakdown. RN33 stated she knew she was not supposed to take a video, acknowledged the facility had a policy prohibiting recording without consent, and confirmed she did not request consent from R36 or determine whether R36 was aware that a video was taken. RN33 stated the facility counseled her for violating the video-recording protocol and protections related to (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident dignity.Review of RN33's Counseling Memo, dated 10/17/25, documented that the facility concluded RN33 made a video recording of a resident without consent and inappropriately instructed another RN to share the unauthorized video with others, violating protocols regarding privacy, documentation, and the protection of resident dignity.Review of the facility's policy and procedure HIPAA (Health Insurance Portability and Accounting Act) Audio, Photography and Video Recording Policy, last approved on 08/2022, documented unless authorized by specific facility staff members, Audio Recordings and/or Photography of Persons Served by Workforce Members and Guests are not permitted under the following circumstances:.During treatment or any type of care being provided to Persons Served.To document behavior, or conditions or any environmental condition of Persons Served.For research purposes or other purposes that violated the HIPAA Privacy Rules and/or State and Federal regulations.