

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 03/27/2025  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                     |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>125023                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                            | (X3) DATE SURVEY<br>COMPLETED<br><br>10/18/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Lanai Community Hospital                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>628 7th Street<br>Lanai City, HI 96763 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |                                                 |
| F 0645<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783</b></p> <p>Based on record review and interview, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR) Level I was completed accurately to determine if Resident (R)7 will have to be referred for a Level II evaluation. As a result of this deficient practice, there was a potential for R7 not receiving the appropriate care and services for his mental condition.</p> <p>Findings Include:</p> <p>Review of R7's medical records conducted. R7 was admitted to the facility on [DATE] for long term placement with a diagnosis of Dementia due to Pick's Disease. Review of the PASARR Level I Screen dated 12/11/20 under Part A revealed that for the second question, Does the SMI (Serious Mental Illness) individual have Dementia?, the box for No was checked.</p> <p>On 10/16/24 at 03:26 PM, a concurrent interview and record review was conducted with the MDS (Minimum Data Set) Coordinator (MDSC), Social Worker (SW) and Director of Nursing (DON) at the nurse's station. Asked MDSC and SW if a PASSAR Level II evaluation was completed for R7. Both MDSC and SW looked in the paper chart and Electronic Health Records (EHR) and were not able to find it. Reviewed PASSAR Level I that was in the paper chart and asked MDSC, SW and DON if the second question on Part A was supposed to be marked as No. DON and MDSC confirmed that since R7's primary diagnosis on the form stated dementia, the box for Yes should have been checked off. MDSC added that if Part A was completed accurately, it would have triggered Part C to be completed which would determine if a referral for Level II evaluation should be made.</p> |                                                                                     |                                                 |

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<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>125023                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                            | (X3) DATE SURVEY<br>COMPLETED<br><br>10/18/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Lanai Community Hospital                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>628 7th Street<br>Lanai City, HI 96763 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                     |                                                 |
| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783</b></p> <p>Based on observations, interviews, and record review, the facility failed to ensure comprehensive person-centered care plans were developed and/or implemented for three residents (Resident (R)3, R4 and R6) in the sample. Specifically, care plans were not developed or implemented to monitor for adverse effects of medications taken for all three residents and to care for the vascular access (a way to reach the blood for hemodialysis) post hemodialysis (treatment to remove waste and excess fluids from the blood) for R3. As a result of this deficient practice, these residents were placed at risk for a decline in their quality of life, and were prevented from attaining their highest practicable physical, mental, and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility.</p> <p>Findings include:</p> <p>Cross Reference to F698 (Dialysis) - pressure dressing not removed as communicated by dialysis facility.</p> <p>Cross Reference to F757 (Drug Regimen is Free from Unnecessary Drugs) - monitoring for adverse effects not documented.</p> <p>1) R3 is a [AGE] year-old resident admitted to the facility on [DATE]. Diagnoses included but not limited to stage 5 chronic kidney disease (kidney failure) and atrial fibrillation (irregular fast heartbeat). Review of medical records revealed that R3 was getting hemodialysis treatments three times a week and is taking Eliquis (anticoagulant medication used to prevent blood clots) twice a day. Observed R3 with the same dressing on her left upper arm on 10/15/24 and 10/16/24. Review of R3's care plan conducted. There were no care plans documented for the use of an anticoagulant and how to care for her vascular access after hemodialysis treatments.</p> <p>On 10/17/24 at 03:49 PM, a concurrent interview and record review conducted with Registered Nurse (RN)1 at the nurse's station. RN1 confirmed that R3's comprehensive care plan did not include interventions to monitor for signs and symptoms of bleeding or bruising and the instruction for the care of R3's vascular access after hemodialysis treatments was not implemented.</p> <p>2) R4 is an [AGE] year-old resident admitted to the facility on [DATE]. Diagnosis included but not limited to alcohol related dementia with behavioral disturbances. Review of medical records revealed that R4 was on escitalopram (antidepressant medication) 2.5 milligrams (mg) daily for major depressive disorder. Comprehensive care plan included monitoring for common side effects like trouble sleeping, nausea, sweating, tiredness and sleepiness. No documentation of monitoring was found in the medical records.</p> <p>3) R6 is a [AGE] year-old resident admitted to the facility on [DATE]. Diagnosis included but not limited to depression. Review of medical records revealed that R6 was on escitalopram 20 mg daily. Comprehensive care plan included monitoring for signs and symptoms of adverse effects to the medication. No documentation of monitoring was found in the medical records.</p> <p>(continued on next page)</p> |                                                                                     |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                     |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>125023                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                            | (X3) DATE SURVEY<br>COMPLETED<br><br>10/18/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Lanai Community Hospital                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>628 7th Street<br>Lanai City, HI 96763 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                     |                                                 |
| F 0656<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>On 10/17/24 at 03:49 PM, a concurrent interview and record review was conducted with RN1 at the nurse's station. Asked RN1 if they document the monitoring for adverse effects of escitalopram for both R4 and R6. RN1 said they document it in the MAR (medication administration record) every shift. Reviewed MAR with RN1, documentation only included behavior monitoring and not for signs and symptoms of adverse effects. RN1 said he will start including specific adverse effects of the medications in the log for both R4 and R6.</p> <p>During an interview with the Director of Nursing (DON) in his office on 10/18/24 at 08:25, DON confirmed that monitoring for the side effects of medications needed to be documented in the MAR, and instructions from the dialysis facility regarding post hemodialysis care for R3's a vascular access should have been added to the comprehensive care plan and implemented.</p> |                                                                                     |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                     |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>125023                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                            | (X3) DATE SURVEY<br>COMPLETED<br><br>10/18/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Lanai Community Hospital                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>628 7th Street<br>Lanai City, HI 96763 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                     |                                                 |
| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>47783</p> <p>Based on observations, interviews and record review, the facility failed to provide care consistent with professional standards of practice for the resident (Resident (R)3) who received hemodialysis (treatment to remove waste and excess fluids from the blood) treatments. Specifically, the facility did not provide post hemodialysis treatment care for R3's vascular access (a way to reach the blood for hemodialysis). This deficient practice could result in preventable vascular access complications that could cause serious adverse health conditions.</p> <p>Findings include:</p> <p>Cross Reference to F656 (Develop/implement Comprehensive Care Plan) - instruction to remove pressure dressing to vascular access not included in care plan.</p> <p>On 10/14/24 at 02:55 PM, Certified Nurse Assistant (CNA)2 said R3 has her hemodialysis treatments on Mondays, Wednesdays and Fridays at the dialysis clinic on the ground floor.</p> <p>On 10/15/24 at 08:39 AM, observed Registered Nurse (RN)1 administer medication to R3 in her room. R3 had two separate dressings to her left upper arm where her vascular access was. RN1 said the dressings were applied by the staff at the hemodialysis clinic after her treatment on 10/14/24.</p> <p>On 10/16/24 at 01:55 PM, observed RN1 administer medications to R3 in her room. R3 still had the dressings to her vascular access. Asked RN1 if they were the same dressings that were observed on 10/15/24. RN1 said they were and that he will remove them before she goes down for her treatment that afternoon.</p> <p>Review of R3's medical records conducted. Reviewed communications between the hemodialysis clinic and the facility. A document dated 08/08/24 from the hemodialysis facility stated, . After a 24-hour period please remove pressure dressing .</p> <p>On 10/16/24 at 03:13 PM, a concurrent record review and interview was conducted with the Director of Nursing (DON) and RN1 at the nurse's station. Showed the 08/08/24 communication to DON and RN1, both confirmed that the dressing should have been removed on 10/15/24 to prevent possible complications to R3's vascular access.</p> |                                                                                     |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                     |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>125023                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                            | (X3) DATE SURVEY<br>COMPLETED<br><br>10/18/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Lanai Community Hospital                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>628 7th Street<br>Lanai City, HI 96763 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                     |                                                 |
| <p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47783</b></p> <p>Based on record review and interviews, the facility failed to ensure adequate monitoring was done for three of five resident (Resident (R)3, R4 and R6) sampled for unnecessary medications. The facility was not documenting if R3 was being monitored for signs and symptoms of bleeding and if R4 and R6 were being monitored for adverse effects of psychotropic medications. As a result of this deficient practice, these three residents were put at risk for avoidable adverse health complications related to her health condition and the use of anticoagulants and antidepressants.</p> <p>Findings include:</p> <p>Cross reference to F656 (Develop/Implement Comprehensive Care Plan) Facility did not implement interventions to monitor for adverse effects of psychotropic drugs and develop a care plan for the use of anticoagulant.</p> <p>1) R3 is an [AGE] year-old resident on Eliquis (anticoagulant) 2.5 mg (milligrams) twice a day. Documentation of staff monitoring for the signs and symptoms of bleeding was not found in R3's chart.</p> <p>2) R4 is an [AGE] year-old resident on escitalopram (antidepressant medication) 2.5 mg daily for major depressive disorder. Documentation of staff monitoring for the adverse effects of the medication was not found in the medical records.</p> <p>3) R6 in a 71-year-old resident on escitalopram 20 mg daily for depression. Documentation of staff monitoring for the adverse effects of the medication was not found in the medical records.</p> <p>On 10/17/24 at 03:49 PM, a concurrent interview and record review was conducted with Registered Nurse (RN)1 at the nurse's station. Asked RN1 if they monitor residents for sign and symptoms of adverse effects of medications like psychotropics and anticoagulants. RN1 said they monitor and document it every shift in the MAR (medication administration record). Reviewed MAR for R3, R4 and R6 with RN1. Documentation for adverse effects of psychotropics and anticoagulant were not found. RN1 said he will start including it in the MAR.</p> <p>On 10/18/24 at 08:25 AM, an interview was conducted with the Director of Nursing (DON) in his office. DON confirmed that the monitoring for signs and symptoms of bleeding for R3 and adverse effects of antidepressants for R4 and R6 should have been documented in the MAR every shift.</p> |                                                                                     |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                     |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>125023                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                            | (X3) DATE SURVEY<br>COMPLETED<br><br>10/18/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Lanai Community Hospital                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>628 7th Street<br>Lanai City, HI 96763 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                     |                                                 |
| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>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.</p> <p>47783</p> <p>Based on observations, interview and record review, the facility failed to ensure all medications and blood glucose testing supplies were labeled in accordance with professional standards. Proper labeling is necessary to promote safe administration practices and decrease the risk for medication errors. Proper labeling of blood glucose testing supplies is necessary to ensure the efficacy of the supplies used to test the blood glucose meter for accuracy. This deficient practice has the potential to affect all residents in the facility.</p> <p>Findings include:</p> <p>1) On 10/15/24 at 08:26 AM, inspection of the medication cart was conducted with Registered Nurse (RN)1. Three insulin syringes were found in the top drawer of the cart. Asked RN1 if all three insulin syringes were currently being used for the residents, RN1 confirmed that they were. All three syringes had a red sticker where RN1 said they would write down the open and discard dates. Asked RN1 how long are the syringes good for once they are opened, RN1 said, 28 days. Observed one of the three syringes did not have the open and discard dates written on the red sticker. RN1 said the dates are supposed to be written on the sticker so they will know if they can still use the medication.</p> <p>On 10/18/24 at 08:25 AM, an interview was conducted with the Director of Nursing (DON) in his office. DON confirmed that the staff are supposed to write the open and discard dates of the insulin syringes on the red sticker.</p> <p>Review of facility policy titled Storage of Medications and solutions in Resident Care Areas stated, . Refrigerated insulins must be dated when opened and discarded after 4 weeks as per manufacturer's specifications . Humulin after twenty-five [sic] (28) days .</p> <p>2) On 10/15/24 at 08:31 AM, inspected glucometer (device used to measure glucose in the blood), test strips and control solutions that were kept at the nurse's station with RN1. Observed test strips and both control solutions were not labeled with an open and discard dates. Asked RN1 how often do they test the glucometer. RN1 said they test it once a day. When asked if the test strip and control solutions in the case were being used to test the glucometer, RN1 said, Yes. Asked RN1 how long are the test strips and control solutions good for once opened. RN1 said 120 days for the test strips and 90 days for the control solutions. RN1 added that they should have written the open and discard dates on both the strips container and control solutions so they will know when to discard them.</p> <p>Review of the facility policy titled POCT (Point of Care Testing) Blood Glucose Bedside Testing stated, . Write the expiration date on every new Test Strip and Quality Control vial . Quality Control Solution will expire in 90 days from the date opened .</p> |                                                                                     |                                                 |