

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125023	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Lanai Community Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 628 7th Street 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on policy review and interview, the facility failed to review its infection control plan on an annual basis. The deficient practice inhibits the facilities ability to effectively implement its infection control prevention plan and has the potential to affect all of the residents in the facility by placing them at an increased risk for illness. Findings include: On 04/01/26, review of the facility's Infection Control Pan 2024 noted a reviewed and revised date of 04/2024. In section 5.1, Plan Evaluation, 5.11.1 states In preparation for the annual planning and revision of the Infection Control Plan, all components of the current plan will be evaluated to determine compliance, trends, and continued applicability to the Infection Control Plan .On 04/01/26 at 2:11 PM, interviewed the Infection Preventionist (IP) in the surveyor conference room. IP was asked when the Infection Control Plan was last reviewed and IP noted he was not sure and would check and get back to the surveyor.On 04/01/26 at 2:46 PM, during an interview with the IP, he confirmed the Infection Control Plan was last reviewed on 04/2024 and was currently under review.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and interview, the facility failed to ensure that the personal information and clinical records of resident (R)12 were protected. As a result of this deficient practice, residents are at risk of their health information not remaining private. Findings Include: On 03/31/26 at 01:00 PM, observed the computer terminal (located on the left-side corner of the activities room) with R12's electronic health record (EHR) left open and accessible to any passerby. The screen included R12's flowsheets, diagnosis, and other healthcare information. Concurrent interview with Certified Nurse Assistant (CNA) 1 stated that she left the EHR open and forgot to exit out when passing resident food trays. CNA1 acknowledged that closing out the chart is important for the protection of residents' health information and to comply with the Health Insurance Portability and Accountability Act (HIPPA). On 03/31/26 at 01:00 PM, interview with the Director of Nursing (DON), confirmed that the resident's chart should be exited out when it is not in use to comply with HIPPA requirements. On 04/01/26 at 09:00 AM, review of the facility's Premises Information Security and Privacy policy with a reviewed and revised date of 09/2023, in the 5.7 System/Device and Electronic Media Security section, it states MHS implements physical safeguards for computing systems/devices, medical devices, and electronic media used to access, transmit, receive and store non-public information. 5.7.1c. Computing systems/devices and electronic media displaying non-public information must be positioned to minimize the viewing of such information by unauthorized persons. Physical barriers/devices such as screen guards or privacy screens should be utilized as appropriate and necessary.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide written notice of the discharge to the hospital to the resident's representative and provide a written notice to the office of the Long-Term Care Ombudsman (LTCO) for one of one resident (Resident (R) 6) sampled for hospitalization. The deficient practice potentially affects the rights of the resident and resident's representative to ensure protections are in place; and facility practices related to transfer and discharge are known to the office of the LTCO. Findings include: On 03/31/26, R6's electronic health record (EHR) was reviewed. R6 was discharged to the Emergency Department (ED) on 01/24/26 then admitted to the hospital per medicine history and physical note dated 02/04/26. admission date: 01/28/26. R6 is a [AGE] year-old female with a history of end stage renal disease (ESRD) and dementia who developed chest pain and was seen in the ED. It was felt that a pulmonary embolism (PE) needed to be excluded and she was transferred to the acute care hospital for further evaluation. On 03/31/26, review of the hospitalization information from the Administrator noted R6 was hospitalized from [DATE] to 01/28/26. The written notification of R6's discharge to the hospital that was sent to the resident's representative and the LTCO office was not provided for review. On 03/31/26, interview with the Administrator revealed there was no written documentation of notification sent to R6's representative or to the LTCO office. On 03/31/2026, review of The Patient Discharge - Long Term Care (LTC) Unit policy with reviewed date of 10/2022, states: To provide guidelines for documentation and care of patients transferred between units in the facility. The family shall be notified of the change of level and room .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to develop a person-centered comprehensive care plan for one of one resident (Resident (R) 7) sampled for dental services and skin conditions. Findings Include: Cross-reference to F791R7 is a [AGE] year-old female, admitted to the facility on [DATE] with a primary diagnosis but not limited to stroke, hemiplegia affecting right side and aphasia. On 03/30/26 at 10:00 AM, observed R7 in bed, awake, able to mumble words when spoken to. R7's right hand flaccid with notable right-hand contracture. R7 with brief on, with no visible indwelling catheter assessed. On 03/31/26 at 11:30 AM, interview with R7's family member (FM) 1, noted that R7 is prone to having skin issues. FM1 stated that for the last couple of months, R7 seemed to have some kind of skin problem. FM1 also noted that she is worried about R7's worsening dental condition and was not sure what can be done about it. FM1 is afraid that R7's teeth issues may affect her eating. 1) On 03/31/26 at 12:00 PM, review of the facility's Alert Charting list noted that R7 had at least 16 documented skin issues from 11/25/25 to 03/11/26. R7 is prescribed Clobetasol 0.05% ointment twice a day and Triamcinolone Acetonide 0.1% ointment for rash/itching. Review of R7's care plan noted topical corticosteroids were not included as an intervention. 2) On 03/31/26 at 12:00 PM, review of R7's Minimum Data Set (MDS), a federally mandated assessment for all residents in Medicare or Medicaid certified nursing homes, indicated that R7 was incontinent of both bowel and bladder elimination and did not have an indwelling catheter on admission. Review of R7's care plan included goals and interventions for indwelling catheter care. 3) On 03/31/26 at 12:00 PM, review of R7's Basic Oral Assessment flowsheet noted that on 04/20/25, R7 had plaque and dental caries. Review of R7's care plan did not include any goals or interventions to address dental care. On 03/31/26 at 1:48 PM, interview with Charge Nurse (CN) confirmed that the topical corticosteroids and dental plan of care were missing. CN acknowledged that it should have been included in the care plan as it directs R7's care. CN also confirmed that R7 did not have any indwelling catheter since admission and catheter care should not have been included. CN also admitted that the care plan created for R7 was a bundled care plan (standardized care plan) chosen on admission and agreed that it should have been individualized based on R7 current needs. On 03/31/26 at 02:00 PM, interview with the Director of Nursing (DON) confirmed that the residents' care plans should be individualized and reflect current needs. On 04/01/26 at 10:00 AM, review of the facility's Care Planning policy, with a review and revised date of 02/2020, in the Purpose section, it reads, To provide an individualized plan of care for patients. In the Provisions/Procedures section, it states 5.2 The plan of care shall be individualized, based on the diagnosis and patient assessment.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to revise the care plan for one of two residents (Resident, (R), 7) sampled for limited range of motion (ROM). The facility did not revise the care to include the application of a towel splint for R7's right-hand contracture. This deficient practice puts R7 at risk for worsening contractures. Findings Include: R7 is a [AGE] year-old female, admitted to the facility on [DATE] with a primary diagnosis but not limited to stroke, hemiplegia affecting right side and aphasia. On 03/30/26 at 10:00 AM, observed R7 in bed, awake with noticeable right arm flaccidity and right-hand contracture. No hand or towel splint applied. On 03/31/26 at 10:00 AM, observed right-hand contracture with rolled towel in place. On 03/31/26 at 01:00 PM, review of R7's care plan to address contractures did not include intervention of towel application to right hand. The care plan which was initiated on 11/12/25 also noted that R7 did not require a splint. On 3/31/26 at 01:48 PM, Charge Nurse (CN) confirmed that the care plan was not revised to include towel application to R7's right-hand contracture. CN also stated that they have been applying the towel to prevent moisture and accumulated sweat to R7's right hand. CN acknowledged that revising the care plan is important as it reflects the current needs of the residents. On 03/31/26 at 02:00 PM, interview with the Director of Nursing (DON) confirmed that the residents' care plans should be individualized and revised to reflect the residents' current needs. On 04/01/26 at 10:00 AM, review of the facility's Care Planning policy, with a review and revised date of 02/2020, in the Purpose section, it reads, To provide an individualized plan of care for patients. In the Provisions/Procedures section, it states 5.5 The plan of care shall be updated with revisions reflecting the reassessment of needs of the patient on a regular basis.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interviews and record review, the facility failed to re-schedule a follow-up dental appointment for one of one resident (Resident (R), 7) sampled for dental services. This deficient practice has the potential to affect all residents currently residing in the facility. Findings Include: On 03/31/26 at 11:25 AM, interview with R7's family member (FM)1 noted that R7's teeth are getting worse and was not sure what could be done about it. FM1 stated she is worried that it will affect R7's eating. On 03/31/26 at 02:31 PM, interview with Charge Nurse (CN) confirmed that R7 did have an appointment with the health clinic on the island but initially refused. CN stated subsequent follow-up appointment could not be accommodated by the clinic, and the facility also failed to reschedule appointment. CN also acknowledged that R7's refusal and dental issues were not included in R7's care plan. On 03/31/26 at 12:00 PM, review of R7's Basic Oral Assessment flowsheet noted that on 12/23/24's assessment, R7 had plaque and was referred for dental consultation and had an appointment on 06/15/25. Subsequent assessments made on 01/21/25 and 04/20/25, noted that R7 had plaque and caries with dental appointment still scheduled for 06/15/25. The next assessment due date was scheduled for 07/28/25, but facility did not provide any further documentation of assessment being completed. On 03/31/26 at 01:00 PM, when asked what happened to the 06/15/25 dental appointment, CN provided a nursing note dated 06/16/25, written by Registered Nurse (RN) 1 that an email was received from the health clinic that they could not accommodate R7's dental appointment on 06/27/25. RN1 spoke with clinic staff who stated they would call the facility with a new dental appointment for R7, but according to CN no call back was received from the health clinic and facility staff missed re-scheduling R7's dental appointment.		