STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125040	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Hilo	944 West Kawailani Street Hilo, HI 96720

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on observation, interviews, and record/document review, the facility failed to provide supervision to one resident (R)1, of a sample size of three, who was left alone in the facility van for an unknown period of time. As a result of this deficient practice, R1 was left in an unsafe environment with a high potential for negative physical and/or mental health outcomes. This deficient practice could affect any resident that used the transport van. After the event, the facility implemented interventions to reduce the risk of a similar event in the future and met the criteria for past noncompliance. Findings include: 1) R1 was a [AGE] year-old female resident at the facility since her readmission on 03/16/2022. Her past pertinent medical history included hypertension, Type 2 Diabetes Mellitus, dementia without behavioral disturbance, generalized weakness, and end stage renal disease. P1's BIMS (Brief Interview for Mental Status) on the MDS (Minimum Data Sheet) dated 03/22/2025 was five, which suggest severe cognitive impairment. She required one person assist to extensive assist to transfer and spent the majority of her day in a wheelchair (w/c). R1 was scheduled for dialysis treatments three time a week at an offsite dialysis center. The facility owned two vans and employed drivers/transport staff, who were scheduled to take residents to and from appointments outside the facility. R1 was transported to her dialysis appointments in her wheelchair, by the facility transport van. On 02/19/2025 at approximately 12:00 PM, when R1 returned to her unit after dialysis, she reported to staff when the van returned to the facility, the driver left her alone. 2) The facility encourages Residents/families to share concerns, and utilizes a form titled Concern and Comment Form to forward their concern to leadership. Reviewed the Concern and Comment Form, the Assistant Director of Nursing (ADON) completed for R1 on 02/19/2025 at 12:20 PM. The form included: Please include in detail your concern, comment, or commendation: He left me. I was all alone. I didn't know what to do (handwritten by ADON). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/2025 at 09:10 AM, interviewed Registered Nurse (RN)1, who often worked with R1. She said the staff get her ready to leave on dialysis days around 05:00 AM, and the pre-dialysis vitals are taken around that time. RN1 explained the transporter will come to the unit and take her to the van, usually leaving the unit about 06:00 AM. She said they work together, and the unit staff will assist with taking resident to and from the van as needed. RN1 said when R1 returns, they check the dialysis access site, and take vitals again. She stated on 02/19/2025, the CNA (certified nurses assistant) told her R1 was late getting back from dialysis. She said she thought maybe the van had to stop somewhere and was delayed. She said when R1 returned to the unit, she made a statement that the driver parked, closed the doors, and left her in the van. RN1 said R1 was flustered and very emotional at the time. After the event, they were able to calm her, and she returned to her routine, with a visit with her son that night. 7) On 04/30/2025 at 11:08 AM, observed the transport van arriving back to the facility. The driver backed into a space in front of the facility, parked, and immediately prepared the ramp to unload Residents. One Resident was ambulatory and accompanied by staff. The other two were in wheelchairs, and taken off the van in a timely, organized manner, each accompanied by staff. No resident was left alone at anytime. 8) The facility provided documentation of corrective actions taken to prevent a similar accident from occurring in the future, which included: Revised the orientation for new schedulers, drivers and transporters to include the transportation staffing policy. On 02/26/2025, a new policy was implemented to always have a minimum of two facility staff, a transporter and driver, on the van at all times. Depending on the type of appointments, three staff may be scheduled. On 02/26/2025, the DON directed the staff scheduler to implement the new policy and provided education as to the importance to ensure compliance. On 02/26/2025, the DON communicated verbally with transport staff, the new policy to have a driver with a transporter for each van and always have two staff to ensure residents are not left unsupervised. 9) Review of the van/transporter work schedule for May 2025, confirmed minimum staffing of one driver and one transporter.