

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

Printed: 06/25/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Hilo		STREET ADDRESS, CITY, STATE, ZIP CODE 944 West Kawaihāni 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure an injury of unknown source was reported immediately to the State Agency (SA), but not later than 2 hours after the allegation was made, which resulted in serious bodily injury. Resident (R) 10 sustained a serious injury of unknown origin to the Right Lower Extremity (RLE). The facility did not report the injury of unknown origin to the SA. As a result of this deficient practice, residents are at risk for the potential of harm. Findings include: Cross Reference to F610: Investigate and F697: Pain Management On 03/25/26 at 10:15 AM, reviewed the facility profile in the IQIES database. The database did not contain a Facility Reported Incident (FRI), initial or completed report, for the injury identified on R10's RLE. On 03/30/26 at 01:15 PM, conducted a review of R10's Electronic Health Record (EHR). The resident was admitted to the facility on [DATE]. The Nursing admission Tool completed on 02/02/26 at 12:50 PM, which is the nursing admission assessment, documented A. Skin Conditions documented a rash on the lower back, pink discoloration 15 x 14 cm, tip of nose 1.3 x 1 cm scab (malignant neoplasm) toenails with onychomycosis on the left greater toe avulsed toenail, and surrounding skin dry 3 x 3 cm. There was no documentation of bruising and swelling to the resident's RLE. A progress note written on 02/03/26 at 00:00 AM (midnight) documented staff called R10's Power of Attorney (POA) and informed her of bruising to the RLE. The RLE bruising was not documented on the Nursing admission tool (completed 02/02/26) used to assess R10 on admission, constituting a new injury, occurred after admission. No source of the injury was identified at the time the injury was reported by staff. A progress note on 02/03/26 at 05:00 PM documented, Resident was noted with a bruise to the RLE, below the knee (20 cm [centimeters] x 7cm in length). Resident does not recall how the bruise occurred. Although there are speculations as to the origin of the injury to the RLE, there is no documentation of an investigation conducted by the facility to ensure the injury was not a result of abuse or neglect. Thus, the facility should have conducted a formal investigation into the origin of the injury. A photograph taken on 02/03/26 at 05:03 PM, documented a dark red bruise to the RLE, below the knee which appears to measure the documented 20 cm x 7 cm. In addition to the dark red bruising, there was light yellow/purple bruising which encompasses R10's RLE from below the knee to the shin. On 04/01/26 at 12:37 PM, inquired with the Administrator if the facility reported R10's injury of unknown origin to the SA. Administrator confirmed the facility did not investigate or report R10's injury of the RLE to the SA due to family later reporting it could have happened when the transporting company brought the resident to the facility. However, an interview was conducted with Family Member (FM) 1 on 03/31/26 at 04:25 PM via telephone. FM1 informed that the facility insisted that the family stated the injury was a result of the resident's admission transfer with the transporting company. FM1 insisted that the family did not report that and it was a new bruise sustained after admission. The family provided a verified audio recording for 02/03/26 from approximately 06:45 PM to 08:35 PM. During this time the recording documents the family urging the facility to do x-ray sooner than the next day due to the severity of the injury to R10's RLE and did not mention the origin of the injury as being sustained from the admission transport to the facility. It is clear in the audio recording that the family (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is asking staff how the resident sustained this injury and if the resident was up in a wheelchair that day. The recording also documents family member repeatedly telling staff that something is wrong with R10; the resident was vomiting and cognition was declining. R10 is normally alert and oriented to person, place, time, and situation. However, the resident presented as alert and oriented to person only. Due to the unknown origin of the injury, the extent of the injury, and the potential for abuse and/or neglect to have occurred, the facility should have reported the injury to the State Agency.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to investigate an injury of unknown origin to rule out the potential for abuse. Resident (R) 10 sustained a serious injury of unknown origin to the Right Lower Extremity (RLE). An investigation was not conducted into the origin of the injury and potential for abuse was not ruled out. As a result of this deficient practice, all residents are at risk for potential abuse until a thorough investigation is completed. Findings include: Cross Reference to F609- Reporting to the State Agency and F697- Pain Management On 03/30/26 at 01:15 PM, conducted a review of R10's Electronic Health Record (EHR). The resident was admitted to the facility on [DATE]. The Nursing admission Tool completed on 02/02/26 at 12:50 PM, which is the nursing admission assessment, documented A. Skin Conditions documented a rash on the lower back, pink discoloration 15 x 14 cm, tip of nose 1.3 x 1 cm scab (malignant neoplasm) toenails with onychomycosis on the left greater toe avulsed toenail, and surrounding skin dry 3 x 3 cm. There was no documentation of significant bruising and swelling to the resident's RLE. On 02/03/26 at 05:00 PM a progress note documented, Resident was noted with a (new) bruise to the RLE, below the knee (20 cm x 7cm in length). Resident does not recall how the bruise occurred. The origin of the bruising and swelling are significant and warranted x-rays. Review of the resident's admission Assessment tool did not document a bruise or swelling to R10's RLE, indicating the injury occurred after the resident was admitted to the facility. On 04/01/26 at 12:27 PM, conducted an interview with the Administrator. Inquired if an investigation was conducted to ensure the new bruise was not a result of abuse. The Administrator confirmed an investigation was not conducted because the family thought the injury may have been from the resident's admission transfer the day before. However, an interview was conducted with Family Member (FM) 1 on 03/31/26 at 04:25 PM via telephone. FM1 informed that the facility insisted that the family stated the injury was a result of the resident's admission transfer with the transporting company. FM1 insisted that the family did not report that and it was a new bruise sustained after admission. The family provided a verified audio recording for 02/03/26 from approximately 06:45 PM to 08:35 PM. During this time the recording documents the family urging the facility to do x-ray sooner than the next day due to the severity of the injury to R10's RLE and did not mention the origin of the injury as being sustained from the admission transport to the facility. It is clear in		

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide effective and timely pain management to a resident experiencing pain. Resident (R) 10 complained of pain 10 out of 10 (10/10 on the pain scale, indicating severe, intense agony) to the lower back after being in a wheelchair (w/c). The physician ordered an opioid medication at 01:47 PM, which was not administered until 09:00 PM, despite the resident's sustained pain level 8/10, which is severe. The delay in administration of an effective medication, the absence of non-pharmacological intervention, failure to seek higher level of care due to unrelieved pain caused R10 to experience unrelieved severe pain for 7.15 hours. As a result of this deficient practice, residents are at risk of physical harm. Findings include: Cross Reference to F609- Reporting of Alleged Violations & F610- Investigate Alleged Violations. On [DATE] at 09:06 AM conducted a review of R10's Electronic Health Record (EHR). R10 was admitted to the facility on [DATE] with diagnosis of [DATE] at 11:04 AM- documented the resident was in a wheelchair in the dining room and appeared comfortable. An interview with the author of the progress note on [DATE] at 01:59 PM, confirmed the note was written prior to R10 complaint of lower back pain and the resident was not tolerating being in the wheelchair, thus was transferred back to bed. At 12:54 PM the Medication Administration Record (MAR) documented Acetaminophen 650 milligrams (mg) was administered for 10/10 lower back pain. The Pain Scale also documented on [DATE] at 12:54 PM- 10/10, which indicates severe/intense agony pain. At 01:03 PM, a progress note documented R10 stated that Acetaminophen does not normally work but will take it and wanted stronger medication for pain management. At 01:23 PM, a progress note documented the follow-up evaluation of the Acetaminophen administered was 08/10 indicating severe debilitating pain. There was no documentation of non-pharmacological interventions implemented or attempted as a standard of practice. R10's pain scale documented at 01:23 PM- 8/10, indicating severe debilitating pain. At 01:47 PM, the Medication Administration Record (MAR) documented the physician ordered Hydrocodone-Acetaminophen 5-325 mg for pain which was not administered. At 05:00 PM, the pain scale documented R10's pain was an 8/10, indicating severe debilitating pain. Acetaminophen 650 mg and Hydrocodone-Acetaminophen 5-325 mg were not administered to manage the resident's severe pain. Also, non-pharmacological interventions were not implemented. At 09:00 PM, R10 was administered Hydrocodone-Acetaminophen 5-325 mg, approximately 8 hours after Acetaminophen 650 mg was given and 7.15 hours after the order for Hydrocodone-Acetaminophen 5-325 mg was ordered by the physician. At [DATE] at 01:50 AM, a progress note documented that R10 was pale and lethargic. Right Lower Extremity (RLE) inner leg below knee with extensive bruising. & (and) having pain with slight movement. Review of the hospital records documented obvious deformities to the right tibia, RLE and uncertain of how that occurred. R10 arrived at the emergency room at 02:39 AM and expired at 03:20 AM. An interview was conducted with Physician (P) 1 on [DATE] at 11:06 AM. P1 reported assessing the resident on [DATE] in the morning and the resident was not in any pain and appeared comfortable throughout the assessment. On [DATE] at 01:59 PM, conducted an interview with Registered Nurse (RN) 9. RN9 confirmed on [DATE], R10 was up in a wheelchair and became uncomfortable and was assisted back to bed. On [DATE] at 04:25 PM, conducted a telephone interview with Family Member (FM) 2. FM2 confirmed R10 could not tolerate being in a wheelchair and had not been in one for approximately two years ago. R10 could not tolerate the wheelchair due to becoming dizzy and contractures which prevented her from sitting upright.		