

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

Printed: 10/09/2026
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 07/02/2026
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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review the facility failed to provide unopened mail to one of four residents sampled for mail delivered to them. Resident (R) 23 reported approximately six months ago four bank statements from her credit union and two personal letters that included checks made out to her were delivered opened to her. This deficient practice violates R23 resident rights and may cause undue emotional stress. Findings Include: On 07/01/2026 at 09:29 AM met with four Residents (R) 169, R130, R185 and R23 and two staff, Activities Director (AD) and Discharge Coordinator (DC), in the conference room to conduct the Resident Council interview. During this interview surveyor asked residents, Is mail delivered unopened and on Saturdays? R23 spoke up and said No. Inquired of R23 what happened and she stated she had four pieces of mail that were opened from her credit union with bank statements and two personal letters with checks that were coming to her for her to sign to give to the facility. Inquired when this occurred and R23 stated, This occurred about 6 months ago. Inquired of residents and staff who receives the mail when it is delivered to the facility and R23 stated the business office. Inquired who surveyor should speak to, the AD and DC stated the name of the Accounts Receivable staff. On 07/01/2026 at 10:22 AM met with the Business Office Accounts Receivable staff in the conference room. Inquired if the facility opens residents mail before they deliver mail to residents and she stated they do not open resident's mail. Inquired if there is ever a reason for facility staff to open resident's mail and she stated, Only for rep payees (if the facility is the rep payee for the resident). Inquired if she could provide surveyor with a list of the residents who the facility is the rep payee for. Staff also stated there is one resident who is not the responsible party and she will include this resident on the list. Business Office Accounts Receivable staff was able to provide the copy of the list of resident's names soon after and review of this list found R23 was not listed as having the facility as the rep payee for her. On 07/01/2026 at 2:53 PM met with and interviewed the Director of Nursing (DON) and Administrator in the Administrator's office. Inquired if resident's mail is supposed to be delivered to residents unopened and they confirmed this.		

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 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 reviews, staff interview and review of policy, the facility did not show proof of discharge written notification for one Resident (R)11 of two sampled for hospitalization. Findings include: Review of Electronic Health Record showed that R11 was discharged to the hospital on [DATE]. Notice of Resident Transfer or Discharge form showed that the resident's representative was notified, via phone, of the transfer or discharge. During a staff interview on 07/01/26 at 2:35 PM, Social Services Director explained that the facility mailed R11's Transfer or Discharge form to the representative but could not provide any verification. Review of facility policy on Transfers and Discharges read; Policy, the facility will follow the limited conditions under which CMS has outlined how the facility may initiate transfer or discharge of a resident, the documentation that must be included in the medical record and who is responsible for making the documentation. Additionally, the facility will ensure the information that must be conveyed to the receiving provider for residents being transferred or discharged to another healthcare setting is provided in accordance with federal guidance. The facility will also provide transfer/discharge notice to the resident/responsible party in accordance with federal regulations.		

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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 observations, interviews and record reviews, the facility failed to develop a written person-centered comprehensive care plan for two of three residents (Resident (R) 48 and R164) sampled for skin conditions. As a result of this deficient practice, staff did not have the information to adequately care for both resident's skin conditions. Findings include: 1) On 06/29/26 at 11:52 AM, observed R48 walking in the hallway with the assistance of the physical therapist. R48 had a dressing to his left shin. Queried R48 what happened to his shin. R48 said he had a wound that was slow to heal and was acquired before he was admitted to the facility on [DATE]. Review of R48's Electronic Health Record (EHR) was conducted. R48 is a [AGE] year-old resident admitted to the facility for short-term rehabilitation services after sustaining a cervical (neck) fracture from a fall at home. R48 also sustained multiple bruises and wounds as a result of the fall. Further review of the EHR revealed that the wound on his left shin was cellulitis (bacterial skin infection that causes redness, swelling and pain in the infected skin and underlying tissues) and an order to cleanse it with normal saline, apply Mupirocin (topical antibiotic) ointment and apply a dressing to the wound was given by the provider on 06/23/26. There was no care plan implemented for R48's left shin cellulitis. On 07/01/26 at 1:04 PM, a concurrent interview and record review was conducted with Registered Nurse (RN) 17 by the nurses' station. Queried RN17 if there was a care plan developed for the cellulitis to R48's shin. RN17 reviewed the current care plan in the EHR and confirmed that there was no care plan developed for the management of R48's cellulitis. 2) On 06/30/26 at 10:07 AM, an observation and interview were conducted with R164 in the main dining area on the third floor. During the interview, observed both of R164's feet were reddened, shiny and with small open wounds. Queried R164 about the condition of her feet. R164 said a few months ago, she had edema (swelling due to excess fluid in the body's tissues) to both legs and the top of her feet developed some open sores. R164 said the skin is shiny because the staff apply Aquaphor (skin-protecting ointment used to heal dry, cracked skin and minor cuts) after they cleanse it with normal saline. Review of R164's EHR was conducted. R164 is an [AGE] year-old resident admitted for long-term placement on 02/23/24. Diagnoses included but not limited to peripheral vascular disease (circulation disorder caused by narrowing, blockage or spasms in the blood vessels), protein-calorie malnutrition and polycythemia vera (rare blood cancer where the bone marrow overproduces red blood cells that thickens the blood). Orders for the care of R164's feet included, saline wound wash every evening, application of Aquaphor, and covering the feet with gauze when in bed. There was no care plan found for the management of R164's skin condition of her feet. On 07/01/2026 at 09:43 PM, concurrent interview and record review was conducted with Licensed Practical Nurse (LPN) 13 in the nurses' station. LPN13 checked in the EHR and confirmed there was no care plan developed for the skin condition to R164's feet and added she will bring it to the attention of the interdisciplinary team. On 07/01/26 at 2:53 PM, an interview was conducted with the Director of Nursing (DON) in the conference room. The DON confirmed that the care plans for R48 and R164 need to be updated to include care for their skin conditions.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview the facility failed to assure one of five Residents, (R) 10, reviewed for unnecessary medication, had a completed Medication Informed Consent form that was shared with the resident's representative by phone which ensured the residents representative was informed of the risks versus benefits of R10 taking psychotropic medications. The deficient practice places residents at risk of the right to be informed of treatment. Findings Include: On 06/30/2026 at 3:01 PM record review of R10's Electronic Health Record found he is taking Citalopram Hydrobromide for a mood disorder secondary to his dementia, Trazodone at bedtime for sleep, Risperidone (an antipsychotic medication) twice a day for dementia with psychosis. Review of R10's consents for his medications found there was a Medication Informed Consent form partially filled out on 07/17/2025. The following three boxes of the form were left blank: The following non-drug approaches have proven to be ineffective: Reason why medication was prescribed: Expected benefits to resident: and the proposed course of the medication was not checked off. On 07/01/2026 at 2:53 PM an interview was conducted with the Director of Nursing (DON) in the Administrator's office with the Administrator present. Inquired if the medication consent form for R10's psychotropic medications should have been filled out completely prior to the nurse getting a telephone consent from R1's representative and she confirmed this.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to implement infection control policy related to Enhanced Barrier Precautions (EBP) for one of three residents sampled for skin conditions. The facility did not place Resident (R)48 on EBP who had a wound with cellulitis (a bacterial infection affecting deeper layer of skin) on his left lower leg. This deficient practice places the other residents in the facility at an increased risk of infection. Findings include: R48 was a [AGE] year-old resident admitted to the facility on [DATE] for short-term rehabilitation services. Diagnoses included but not limited to cervical (neck bone) fracture following a recent fall at home, diabetes and history of alcohol abuse. R48 was also admitted with multiple bruises and wounds to all extremities as a result of the fall. On 06/29/26 at 11:52 AM, observed R48 walking in the hallway with the physical therapist assisting him. Observe a dressing to R48's left shin. R48 said he has a wound that was slow to heal. Queried R48 if the wound was acquired at the facility. R48 said he already had the wound before he was admitted to the facility. Review of R48's Electronic Health Record (EHR) conducted. Entry under Progress Notes dated 06/30/26 at 10:12 AM stated, . Tx (treatment) orders in place-Mupirocin External Ointment 2 % (Mupirocin) Apply to L) [sic] (left) shin scab topically every day and evening shift for cellulitis for 10 Days (cleanse with NS, pat dry, apply ointment to scab and surrounding skin and cover with band aid/dry dressing. Dry scab remains with slight surrounding redness . On 07/01/26 at 07/01/26, Observed Registered Nurses (RN)17 provide wound care for R48's left shin wound in his room. No signage was noted at the room's entrance designating R48 to be on EBP. RN17 changed the dressing and applied Mupirocin cream to the wound as ordered. RN17 was not wearing a gown while providing care. Review of facility policy titled Enhanced Barrier Precautions dated 06/05/26 stated, .EBP are indicated for residents with . Infection or colonization . Wounds and/or indwelling medical devices . Examples of high-contact resident care activities requiring gown . Wound care: any skin opening requiring a dressing . On 07/01/26 at 2:53 PM, an interview was conducted with the Director of Nursing (DON) in the conference room. The DON confirmed that R48 should be on EBP due to the wound being identified as cellulitis.		