STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125041	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Liliha Healthcare Center	1814 Liliha Street Honolulu, HI 96817

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 39754 Based on resident interview and policy review, the facility failed to treat one Residents (R) 10 of eight residents sampled, with respect and dignity. As a result of this deficiency, R10 felt the right to a dignified existence was violated. Findings include: Resident interview on 01/29/25 at 12:30 PM, R10 said there were many times where staff were speaking in their native language (not English) and R10 felt staff were talking about him/her. Review of policy on Resident Rights read Policy; The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility . Resident rights; The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility .

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 48351 Based on interviews and record review, the facility failed to provide an environment free from any physical restraint imposed for purposes of convenience, for one of one sampled residents (Resident (R) 5) for restraints. This deficient practice placed R5 at risk for physical harm and has the potential to affect all the residents in the facility. Findings Include: During a Facilty Reported Incident (FRI) investigation, interview was conducted on 01/30/25 with Unit Manager (UM) 2. UM2 stated that Certified Nurse Aide (CNA) 10 approached her on 12/31/24. CNA10 had informed her that while providing personal care, R5 was resisting care by pushing down with her hands. CNA10 decided to wrap R5's hands with the lower portion of her gown so that CNA10 can finish changing her incontinence brief. Interview was conducted on 01/31/25 at 09:35 AM with the Administrator. The Administrator stated that during an investigation interview, CNA10 had mentioned wrapping up R5's hands with the lower portion of her gown. CNA10 confirmed that R5 continued to push her hands down while it was wrapped and that CNA10 did it so that she can perform personal care on her. The Administrator stated that CNA10 had demonstrated what she had done with hand gestures and described the hand wrapping as being tight. A review of the facility policy titled, Restraint Free Environment, with a revised date of 06/01/23 was conducted. The policy documented, The resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience, and not required to treat the resident's medical symptoms.

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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** 43414 Based on interview and record review, the facility failed to ensure one of one resident sampled (Resident (R) 22) for elopement, received adequate supervision to prevent accidents when he was an elopement risk. As a result of this deficient practice, R22 left the facility without authorization. This put R22 at risk of injury or getting hit by a car at a busy street. Findings include: R22 was admitted to the facility on [DATE] with diagnoses, but not limited to, pyogenic arthritis, muscle weakness, difficulty in walking, other abnormalities of gait and mobility, anxiety, depression, cognitive communication deficit, and attention-deficit hyperactivity disorder. Review of R22's admission Minimum Data Set (MDS) with assessment reference date of 12/16/24 found R22's Brief Interview for Mental Status (BIMS) score a 15 (cognitively intact). In Section GG. Functional Abilities and Goals, mobility devices used were cane/crutch and wheelchair. Further documented R22 needed supervision or touching assistance when walking 10 feet and 50 feet. Walking 150 feet, 10 feet on uneven surf and one step (curb) was not attempted due to medical condition or safety concerns. Review of an Event Report completed by the facility on 12/26/24, the facility reported R22 attempted .to exit the facility, through the main entrance, following a visitor out the door on 12/17/24 at approximately 11:30 AM. Social Services Director (SSD), was supervising and observing the resident from his office, which has a window and clear view of the lobby, Resident was seated in a chair, in the lobby. Social Services Director, observed resident stand from chair and head towards the front door. SSD immediately stood from his desk and headed to the found door. At the time the SSD reached the resident, resident made his way through the front door to the outside of the facility The visitor, who the resident followed out of the facility, put his arm out in attempts to redirect resident back in the facility. SSD attempted redirection, not able to redirect resident back into the building. Per SSD, resident stated he wanted to go home Resident is ambulatory and began walking down the facility's entrance ramp and up the street. SSD escorted and supervised resident, walking with resident Facility's transporter witnessed resident and SSD walking on the sidewalk. Assisted SSD by walking behind resident with a wheelchair. Prior to the incident the event report documented R22 attempted to elope and expressed he wanted to return home that morning. On 01/29/25 at 09:01 AM, an interview with Licensed Practical Nurse (LPN) 2 was done. LPN2 confirmed she worked the night before R22 eloped from the facility. LPN2 reported R22 was restless that night and walking in the hallway. Since admission, R22 wanders in the hallway but is redirectable. On 01/30/25 at 08:06 AM, an interview with Certified Nurse Aide (CNA) 6 was done. CNA6 reported on admission and when R22 first arrived at the facility, R22 expressed he wanted to go home and was easily redirectable during the night shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R22's nursing note on 12/11/24 at 11:39 PM documented Received resident up in wheelchair at dining area. Noted to be agitated during beginning part of shift, unable to redirect, want to go home to get some clothes and come back to facility. Called wife, will drop off clothes tomorrow morning. PRN [as needed] Lorazepam 0.5mg [milligrams] give at 6:10pm for behavior issues with relief . On 01/29/25 at 09:22 AM, an interview with Receptionist was done. Receptionist reported a nursing staff asked her to monitor R22 in the lobby on 12/17/24. Receptionist reportedly observed R22 to be sitting in the lobby but had also been observed to get up and walk back and forth. Receptionist was located behind her desk and was not able to continuously monitor him when busy answering the phone or when a visitor enters the facility. Receptionist stated she did not see the resident leave the facility on 12/17/24. On 01/29/25 at 09:38 AM, an interview with Licensed Practical Nurse (LPN) 3 was done. LPN3 was not assigned to R22 but confirmed she worked the day R22 eloped from the facility on 12/17/24. At approximately 09:00 AM the day of the incident, LPN3 reported she was on the phone at the nurse's station when a staff member yelled R22 is outside. LPN3 hung up the phone and located R22 outside of the facility's main entrance door at the end of the walkway ramp to the public sidewalk. LPN3 showed this surveyor exactly where she found R22 outside, a busy main street is located right outside the facility. LPN3 asked R22 where he was going and R22 responded he wanted to go home. LPN3 was able to convince R22 to return the facility. LPN3 confirmed that was the first elopement that day and a second elopement occurred when SSD had followed R22 out of the door. A second interview was done with LPN3 on 01/30/25 at 10:11 AM, LPN2 stated one to one supervision was not provided after the first elopement but close supervision was provided. Inquired who was providing the close supervision, LPN3 was not sure but saw Central Supply Coordinator (CSC) with R22. On 01/30/25 at 10:13 AM, an interview with CSC was done. CSC stated no one asked her to provide supervision or monitor R22. CSC heard he attempted to elope and expressed he wanted to go home so decided to try and talk to him to provide comfort but was unsuccessful at approximately 10:00 AM on 12/17/24. CSC spoke to him for about five to 10 minutes but noticed resident was getting more agitated. On 01/30/25 at 08:45 AM, an interview with Unit Manager (UM) 1 was done. UM1 was on vacation when the incident occurred. UM1 stated if a resident was actively attempting to elope, one on one supervision should be provided. UM1 was not able to confirm if R22 received one on one on 12/17/24 after the first elopement which may have prevented or decreased the risk of R22 eloping the second time that day. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/30/25 at 09:28 AM, an interview with SSD was done. SSD reported he sat with R22 in the morning at the lobby on 12/17/24, prior to the second elopement, and the resident had expressed he wanted to go home and reportedly observed him trying to push the front doors open that morning. No one asked him to monitor or provide close supervision to the resident but does keep an eye on residents when they are in the lobby from his window. SSD reportedly observed R22 go outside the facility main doors after a vendor entered the facility and followed him out the door. SSD continued to encourage R22 back into the facility but was unsuccessful. R22 began walking up the street and SSD continued to follow and attempt to encourage resident back to the facility with casual conversation. R22 reportedly expressed he was going to walk home. The facility's transport driver was on his way back to the facility when he saw R22 and SSD walking up the street and brought a wheelchair and walked behind the resident. While walking up the street, R22 would cross the street with no cross walk or safety awareness. R22 stopped in the middle of the road. SSD reported he positioned himself toward oncoming traffic because of the dangerous situation. SSD was able to convince R22 to sit in the wheelchair and attempted to take R22 back to the facility but R22 stopped the wheelchair and began walking up the street again. R22 crossed the street without looking both way or demonstrate safety awareness. R22 walked toward a residence and sat in front of an unknown residence's home. During this time, the transport driver went back to the facility to inform the administrator. SSD stated that it was not until further into walking that he realized R22 was not coherent to place and referred to the area as Boston. SSD stated he was with the resident for about an hour until the administrator arrived and the administrator was able to redirect R22 back to the facility. On 01/30/25 at 11:02 AM, an interview with Administrator was done. Administrator believed nursing staff knew R22 was missing but was not notified. Only after the transport driver notified him, he became aware that R22 was missing. Administrator did not know R22 left the doors of the facility and made it to the end of the ramp earlier in the morning prior to the incident. Inquired if R22 would have benefited from one on one after demonstrating exit seeking behavior throughout the morning on 12/11/24, Administrator stated it may have prevented or decreased the risk of him actually leaving the facility. Review of the facility's policy and procedure (P&P) Elopements and Wandering Residents reviewed/reviewed 06/2023 documented elopement .occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. Under monitoring and managing residents at risk for elopement in the P&P, Adequate supervision will be provided to help prevent accidents or elopements. The procedure for locating missing resident documented Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol.