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	06/09/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and document review, the facility did not have a process in place to maintain documentation of grievances. Six out of the six grievances sampled, did not meet the documentation requirements for the grievance decision. In addition the facility did not follow their own policy. As a result of this deficient practice, it is unknown what action had been taken, and if Residents/Representatives were satisfied with the outcome. Findings include: 1) Reviewed the facility policy titled Resident and Family Grievance, revised date 01/2025. The policy included: 1. The Administrator has been designated as the Grievance Official . 2. The Grievance Official is responsible for overseeing the grievance process, receiving and tracking grievances though the conclusion .; Issuing written grievance decisions to the resident; . 3. The Social Services Director, in coordination with the Grievance Official, is responsible for conducting any necessary investigations by the facility, ensuring the facility's grievance form is completed for any grievance filed; conducting correspondence with the individual who filed the grievance .; and informing the resident(s) and/or resident representative of their right to a written summary of the grievance, including the outcome of the grievance, and resolution; providing a written summary to the individuals, if requested; completing the Grievance Log, and maintaining grievances for 3 years. 11b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated form, or assist the resident . 11c. The Social Services Director, in coordination with the Grievance Official, will take steps to resolve the grievance, and record information about the grievance, and those actions taken, on the grievance form. 11g. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Social Services Director will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Reviewed the designated form referenced in the policy which is titled Concern Form. The form includes the following: First part of the form: Date of Report, Time of Report, Date of incident, Name of Affected Residents(s), Person reporting the incident with Phone number, Location of incident /Circumstances surrounding incident, Resident account of Incident, Immediate Action Taken and who initiated them. The last question was if the Resident/Family were Satisfied. Second part of the form included: Follow-up needed? (Check box for Yes or No) Reported to: Check box for Administrator, DON (Director of Nursing)/Unit Mgr (manager) Social Services, Maintenance, Housekeeping, Dietary, Laundry, Transportation, other, or NA (not applicable). Departments(s) action taken to prevent recurrence. Complainant Notified? Check box, Yes or No. Department head signature and date, Social Services signature and date, and Administrator signature and date reviewed. 3) On survey entry, a request was made for the grievance log from February 2025 to current. The Administrator provided six individual Concern Forms, which included the following: Resident (R)4 had three concern forms initiated on 04/24/2025, which included the following: - Saw mold and water damage on ceiling in the first floor day room. The form was incomplete and had no immediate action taken, or documentation on the second part of the form regarding investigation and follow up. - Need for more CNA's (Certified Nurse Assistants) during night shift. There were only 2 CNA's [sic] working and had to wait long periods for call light to be answered. The form was incomplete and had no immediate action taken, or documentation on the second part of the form regarding - investigation and follow up. - Notified 3 weeks ago he was missing 1 blue blanket, 1 plaid blanket and one sweater. The form was incomplete and had no immediate action taken, or documentation on the second part of the form regarding investigation and follow up. It is unknown how this was resolved and if R4 was satisfied with the outcome. R5's family member (FM) had one concern initiated on 04/14/2025 and two on 04/16/2025, which included the following: (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 04/14/2025: .called her (FM) to ask if okay for resident to come out to day room for day time stimulation p (after) Covid; Another nurse .talked to her and stated, resident (R5) is out @ the day room, looks tired & sleepy. I (FM) still want my mom to be out @ the same time (11:00-11:30 AM) allow her to sleep after medpass because her meds make her sleepy & if she's still tired, keep her inside the room until she's fully recovered because I don't want her to make other people/resident sick even if she's already covid negative. Actions documented by the Unit Manager (UM)1 were Informed Administrator-Both nurses were verbally educated, reminders added to shift report reminders. The form did not indicate if FM was satisfied, and there was no documentation on the second part of the form. -04/16/2025 at 03:50 PM, FM reported a concern. The form documented the following: Concern was: Nurse called her to get consent for OT (occupational therapy) - OT seen [sic] resident without family's idea. Still waiting for Rehab to provide updates on resident's status with physical therapy and OT evaluation. RNA's (restorative nurse aid) not supposed to walk her yet until PT (physical therapy) provides update with education. Actions taken by UM1: Immediate action taken: Emailed Rehab Director. Provided reminder to RNA as well-verbal reminder to floor nurses- Added to shift report reminders. The form did not indicate if FM was satisfied, and there was no documentation on the second part of the form to indicate the status of R5's PT and OT evaluations. - 04/16/2025 at 05:30 PM, the FM reported a concern: Rotten banana (served during dinner) CN1 documented: Immediate Action Taken: Notified Administrator - went down to kitchen and checked all supplies of bananas, met with kitchen staff. The form did not indicate if Family was satisfied, and there was no documentation on the second part of the form. 4) On 06/09/2025 at 11:50 AM, observed dark spots on the ceiling tile in the first floor day room located by the AC unit, which was reported as a concern by R4 on 04/24/2025. 5) On 06/06/2025, interviewed the Administrator (ADM), who confirmed he was the designated Grievance Official. He stated the facility currently does not have a Social Service Director, and said they followed up on the grievances, but acknowledged they had not been able to keep up with the required documentation. At that time, asked the status of R4's concern about ceiling tile mold, and he replied the issue was referred to maintenance. He went on to say it was not fixed yet, and there was no work order available to document the work request. Inquired if there had been follow up with R4 about the staffing concern, and the ADM said he had reviewed staffing schedules and did not find shortages of concern. He said he had discussed the situation with R4, but had not documented it. The ADM said they had not been able to keep the grievance log up to date with the open Social Services position.

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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. Based on interview and record review, the facility failed to provide evidence that an allegation of abuse was thoroughly investigated for one Resident (R)3 of a sample size of three reviewed for abuse. This deficient practice potentially compromised the protection and safety of all residents on the unit where R3 resided. Findings include: On 02/24/2025 at 07:05 PM, the State Agency (SA) received a facility-reported incident (FRI) for ASPEN Complaints/Incidents Tracking System (ACTS) #11520, documenting an allegation of staff-to-resident abuse by Certified Nurse Aide (CNA)12 to R3. On 06/05/2025, the SA entered the facility to investigate the allegation. On 06/05/2025, the facility provided a copy of the 02/24/2025 Nurse staff schedule for the second-floor unit which revealed four CNAs (including CNA12) and two Registered Nurses (RN) working at the time the incident allegedly occurred (day shift). On 06/05/2025 at 11:30 AM, a review of the facility's investigation packet revealed that the facility obtained information from CNA12. There was no evidence provided to indicate the facility interviewed or obtained statements from the other staff members working at the time of the incident. There was also no evidence of interviews with R3's roommates and other residents residing on the second-floor unit, and no evidence that residents who were not interviewable were assessed for signs and symptoms of abuse. On 06/05/25 at 02:00 PM, an interview was done with the Administrator (ADM) in his office and confirmed that the facility did not conduct interviews with other staff members working at the time of the incident, R3's roommates, and other residents residing on the unit. The ADM stated, The focus was just on that resident. A review of the facility's policy titled, Abuse, Neglect, and Exploitation, last revised 06/2023, under V. Investigation of Alleged Abuse, Neglect, and Exploitation, the following was noted: 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect .has occurred, the extent . 6. Providing complete and thorough documentation of the investigation.

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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 observation, interview and medical record review, the facility failed to make timely revisions to two resident's (R)1 and R2's Comprehensive Care Plans (CP) of a sample size of six. As a result of this deficient practice, staff did not have all the information necessary to effectively address the resident's status, condition, and/or needs adequately so that they could meet their highest potential of physical and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) R1 was a [AGE] year old female admitted to the facility on [DATE]. Her medical history included but not limited to chronic obstructive pulmonary disease, stroke affecting the left side, dysphasia (difficulty swallowing), dementia, Type 2 diabetes, and anemia. R1 was incontinent of bowel and bladder and had a feeding tube (tube placed in stomach) for long term nutritional support. She required one person assist with bed mobility. On 06/09/2025 at 12:00 PM, observed R1 lying in bed and noted she had protective arm sleeves on both arms. Reviewed R1's provider orders, which included an order dated 04/29/2025, for GERI (skin protector) sleeves to bilateral arms for protection. Reviewed R1's nursing progress note, dated 06/03/2025 at 04:37 PM. The note read Resident noted with several small open wounds on BUE (bilateral upper extremities) due to resident's scratching. Reviewed R1's CP, which indicated that she was at risk for skin issues due to fragile skin, but the CP was not updated to include the GERI sleeves to protect her skin. 2) R2 was a [AGE] year old female admitted to the facility on [DATE]. Her medical history included Parkinson's. Reviewed R2's provider orders, which included an order dated 05/08/2025 for Prevalon Boot to R (right) ankle/foot for protection. Monitor for skin breakdown. On 06/09/2025 at 11:55 PM, interviewed RN1 in the first floor nursing station. Inquired why R2 had a boot ordered for her ankle. RN1 demonstrated how R2's Right (Rt) foot rotated out, causing pressure on the ankle bone. At that time, reviewed R2's CP with RN1, who confirmed the boot was not included as an intervention for skin integrity. She said the boot should be in the care plan. On 06/09/2025 at 12:10 PM, accompanied RN1 to R2's room and observed her lying in bed. It was noted that she was not wearing the Prevalon Boot on her Rt foot. At that time, RN1 obtained the boot from the cabinet, and placed it on her foot. Observed a small area of redness to the outside of R2's ankle area, which is the reason the boot was ordered.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, medical record and document review, the facility failed to provide the standard of nursing care to one Resident (R)6 of a sample size of three. Specifically, when R6 was diagnosed with COVID infection, the nursing staff failed to consistently monitor all vitals signs, which would include temperature (T), blood pressure (BP), pulse rate (P), respiration rate (R), and pulse oximetry (O2% - measures oxygen in blood). As a result of this deficient practice, there was a higher risk that changes in condition may be missed. Findings include: 1) R6 was an [AGE] year old female long term resident at the facility. Her medical history included advanced dementia, breast cancer, Type 2 diabetes, major depressive disorder and hypertension. R6 had dysphasia, which affected her ability to communicate and at baseline, she was not alert or oriented. On 03/30/2025 she was diagnosed with COVID infection, and placed in isolation until 04/08/2025. On 04/10/2025, R6 was transferred to the hospital for a higher level of care due to altered mental status and high blood sugar, where she was admitted with diagnosis that included sepsis (life threatening reaction to infection), metabolic encephalopathy (brain dysfunction), respiratory failure, hypernatremia (high sodium levels) and hyperglycemia (high blood sugar levels). 2) After R6 was diagnosed with COVID, the nursing staff were to monitor and record her vital signs each shift (twice a day). Monitoring vitals signs to include T, R, Pulse Oximetry on room air and/or oxygen, P and BP are important to identify early decline of Residents with COVID. Review of the vital signs record from 03/30/2025 to 04/10/2025, revealed the following vital signs were not taken. 03/30/2025: Day shift, No P, No R, No PO2 04/01/2025: No P, No R all day 04/02/2025: No P, No R all day 04/03/2025: No P, No R all day 04/04/2025: No P, No R all day 04/05/2025: No P, No R all day 04/06/2025: No P, No R all day 04/07/2025: No P, No R all day 04/07/2025: Noc shift, No P, No R 04/08/2025: Day shift, No T, No P, No R, No PO2 04/08/2025-04/09/2025: Noc shift, No P, No R, No PO2 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/09/2025: Day shift, No T, No P, No R, No PO2 04/10/2025 Only BP was taken during the day. Just prior to end of shift, at 06:34 PM, a full set of vitals were taken, which were recorded as BP 135/88, P 121, Temp 98.4 (Temporal), R21, PO2 92% on room air. Oxygen was then provided at 2 liters per minute, and her PO2 was recorded to improve at 06:34 PM to be 95%. Review of Nursing Progress notes revealed the following: - 04/10/2025 at 02:05 PM: Daughter visited today shortly before lunch. c/o (complain of) resident appears so sleepy, unable to wake her up, worried and concerned about resident's status especially since she just came out of COVID, she is coughing, looking tired and sleepy. Family met with administrator to discuss concern. chest xray, . CBC (lab test, complete blood count) with diff (differential), bmp (basis metabolic profile), IPRAT q shift (Ipratropium and albuterol/bronchodilater every shift) and PRN (as needed) x 3 days for cough. Endorsed to floor nurse. - 04/10/2025 entered at 04:00 PM: In bed, resident appears sleepy, able to consume 50% breakfast, and CNA (Certified Nurse Assistant) staff was able to feed her lunch with 75% consumed at 02:00 PM. Order of CXR (chest xray) was facilitated, STAT (immediate) cbc with diff and BMP done, awaiting result. Started ipratropium-albuteral at 14:30 (02:30) pm. PRN Tussin administered for coughing, low pitch wheezing assessed before nebulization improved. - 04/10/2025 entered at 10:40 PM: Received resident lying in bed, appears comfortable, however sleepy though responding to tactile stimulation and open her eyes. Around 4:10 (PM), 2 staff assist in bedside care/changed her adult brief . Vital signs .BS (blood sugar) 313 mg/dl (high) at 4:46 (PM). After the daughter expressed concern about R6's condition to the Unit Manager (UM)1 at 02:05 PM, nursing provided a nebulizer treatment. Although lung sounds were documented in the progress notes as above, there was no pre-nebulizer baseline assessment that included pulse, respiratory rate, and oxygen saturation, which is the standard of care (Nursing Fundamentals and Skills, Nebulizer Therapy, November 24,2024). At 03:50 PM, a T and PO2 was taken, but no P, R or BP. In addition, a thorough nursing assessment including level of consciousness should be done in a timely manner after someone expresses concern of resident's level of consciousness. 3) On 06/09/2025 at approximately 02:30 PM, during an interview with UM1, reviewed the documentation of R6's vital signs. At that time UM1 confirmed it was the expectation that vitals were taken twice a day and that they should include T, P, R, PO2, and BP. She agreed the vitals signs were incomplete and did not meet the standard of care.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to have a process in place to ensure resident repositioning to prevent pressure ulcers (damage to the skin with open wound as a result of prolonged pressure). The facility did not have evidence that three of three Residents(R)1, R2 and R6 that were at risk for pressure ulcers, and who required assistance for bed mobility, were repositioned to prevent pressure ulcers. There was not a schedule/regimen for staff to follow and process to document the task. As a result of this deficient practice there is a higher risk residents will develop a pressure ulcer (PU). Findings include: 1) R1 was a [AGE] year old female admitted to the facility on [DATE]. Her diagnosis list included functional quadriplegia, hemiplegia (weakness or paralysis) and hemiparesis (severe or complete loss) affecting left dominant side, following a stroke. She was incontinent of bowel and bladder and required assist of one staff for bed mobility. Reviewed R1's care plan (CP), which included the problem .at risk for alteration in skin integrity . An identified intervention to ensure skin integrity was turn and reposition per rounding schedule. Reviewed R1's nursing progress notes, dated 06/01/2025 at 09:57 PM to 06/08/2025 06:42 PM, which revealed the following entries related to positioning and turning: 06/02/2025, 04:19 PM: .Turned and repositioned for pressure relief and comfort. 06/02/2025, 11:06 PM: .Turned and repositioned for pressure relief and comfort. 06/03/2025, 11:05 PM: .Turned and repositioned for pressure relief and comfort. 06/05/2025, 05:36 PM: .Turned and repositioned for pressure relief and comfort. 06/06/2025, 12:40 PM: .Turned and repositioned q2h (every two hours) and prn (as needed) for pressure relief and comfort. 06/07/2025, 03:47 PM: .Turned and repositioned for pressure relief and comfort. On 06/09/2025 at 12:00 PM, observed R1 lying in bed, positioned on her back. On 06/09/2025 at 03:30 PM, observed R1 lying in bed, in the same position on her back. 2) R2 was a [AGE] year old female admitted to the facility on [DATE]. R2 had limited mobility related to Parkinson's and functional quadriplegia (complete inability to move). She is bedbound and requires assistance of one staff with bed mobility. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reviewed R2's CP, which included the problem .at risk for alteration in skin integrity due to secondary weakness and deconditioning, impaired bed mobility, bladder and bowel incontinence. An identified approach to ensure skin integrity included turn and reposition per rounding schedule. Reviewed R2's medical records that included the CNA task documentation and nursing progress notes. There was no documentation by the CNA's that R2 was turned and repositioned. Review of the Nursing Progress notes from 05/08/2025 (readmitted 04:47 PM) to 06/08/2025 day shift, revealed the following entries related to positioning, with no details: 05/09/2025, 04:24 PM: .Turned and repositioned for pressure relief . 05/12/2025, 04:36 PM: .Turned and repositioned for pressure relief . 05/13/2025, 04:20 PM: .Turned and repositioned for pressure relief . 05/14/2025, 04:41 PM: .Turned and repositioned for pressure relief . 05/19/2025, 05:03 PM: .Encouraged with turning and repositioning . 05/21/2025, 05:14 PM: .Turned and repositioned q 2 h (every two hours) and prn (as needed) for pressure relief 05/22/2025, 04:38 PM: .Turned and repositioned q2H and prn . 05/22/2025, 11:33 PM: .Turned and repositioned for comfort and pressure relief. 05/29/2025, 04:13 PM: .Turned and repositioned for pressure relief . There were no additional notes found 05/29/2025 to 06/08/2025 about positioning. On 06/09/2025 at 12:00 PM, observed R2 lying in bed, positioned on her back. On 06/09/2025 at 03:30 PM, observed R2 lying in bed in the same position. 3) R6 was an [AGE] year old female long term resident at the facility. Her medical history included advanced dementia, breast cancer, Type 2 diabetes, major depressive disorder and hypertension. R6 was incontinent of bowel and bladder and required 1-2 person assist for bed mobility. Reviewed R6's Wound Care progress notes, which revealed on 02/19/2025 she had a wound on her buttocks that measured 1.5 cm (centimeters) length x .2 cm width. The note dated 03/15/2025 documented Wound on Lt (left) buttock is healed this week. Reviewed R6's CP, which included the problem .at risk for alteration in skin integrity R/T (related to) aging process, history of skin bruising. An identified approach to ensure skin integrity included Assist with turning, frequent repositioning, PRN. Reviewed R6's Nursing progress notes 04/01/2025 at 12:59 PM through 04/10/2025, which revealed the following entries r/t positioning: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/02/2025, 11:50 PM: .Turning and repositioning for pressure relief and comfort. 04/04/2025, 11:34 PM: .Turning and repositioning done for pressure relief and comfort. 04/05/2025, 11:38 PM: .Turned and repositioned for pressure relief and comfort. 04/06/2025, 04:04 AM: .Turned and repositioned for pressure relief and comfort. 04/06/2025, 11:21 PM: .Turned and repositioned for pressure relief and comfort. 04/07/2025, 09:09 AM: .Turned and repositioned for pressure relief and comfort. 04/07/2025, 03:40 PM: .Turned and repositioned every 2 hours for pressure relief and comfort. 04/09/2025, 11:34 PM: .Turned and repositioned for pressure relief and comfort. 4) On 06/09/2025 at 12:00 PM. interviewed Certified Nurse Assistant (CNA)2 .She stated she was hired at the facility about two months ago. Inquired what the CNA role was to help prevent pressure ulcers, and she said they are to rotate Residents who are at risk every two hours and make sure they are comfortable. Informed CNA had seen per rounding schedule in Residents' CPs, and asked what that meant. She said she was not sure, but that she thought the second floor still had clocks in the rooms, which indicated when and how to reposition a Resident, and it might have something to do with that. She went on to say the first floor did not have the clocks anymore. On 06/10/2025 at approximately 02:00 PM, during an interview with Unit Manager (UM)1, she confirmed the CNAs currently do not have a process in place to document when a resident is turned or what position they are placed. UM1 said the nurses have been documenting turning and positioning in the progress notes.