

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: 125065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER Legacy Hilo Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 563 Kaumana Drive 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 0686 Level of Harm - Actual harm Residents Affected - Few	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 provide the needed care in accordance to standard of practice to prevent a pressure ulcer (PU) in one Resident (R)88 of a sample size of three. R88 was at high risk of developing a new PU due to her immobility. She was totally dependent on staff for positioning to prevent a PU. There was no evidence in the medical record that staff frequently repositioned R88. As a result, she suffered harm and developed a Stage III (3) coccyx/sacral PU, which increased the risk of infection and complications. This deficient practice has the potential to affect any resident at risk of PU. Findings include: 1) Record review revealed R88 is an [AGE] year-old female that was a long-term resident at the facility with initial admission [DATE]. She had a medical history that included Guillain-Barre syndrome (GBS), paraplegia, spinal stenosis, neurogenic bladder and was cognitively impaired. On 02/03/26, R88 was sent to the hospital for respiratory distress hypoxia. She was readmitted to the facility on [DATE] after discharge from the hospital. On 02/24/26 at 11:00 AM, observed R88 in bed lying on her back. At that time, she said she had pain and pointed to her buttocks. Family members in the room said R88 had a PU on her sacrum. Review of R88's medical records revealed the following: Minimal Data Set (MDS), effective date of 02/16/26, included section GG (functional abilities) documented that R88 was totally dependent on staff for positioning and mobility and did not have the ability to roll from lying on back to left and right side, and return to lying on back on the bed. admission summary dated [DATE], included that R88 had MASD (moisture associated skin damage) to buttocks, zinc oxide cream applied during brief change. There was no PU at this time. Braden Scale (standardized tool to assess the risk of developing a PU based on numeric score) dated 02/13/26, was a total of 12, which signals high risk for pressure injury risk. Nursing note on 02/20/26, at 13:42, included Resident had skin breakdown to her coccyx area discovered during nurse management skin rounds. Resident with a Stage III . orders entered. On 02/26/26 at 01:00 PM, interviewed the Resident Care Manager (RCM), who confirmed there was no documentation of positioning R88 to prevent a PU. At that time the RCM also confirmed R88 did not have a PU at the time of admission, and that she currently had a Stage III PU on her coccyx. 2) Cross Reference F656: Comprehensive Care Plan The facility failed to develop and implement a comprehensive person-centered care plan for R88. The CP developed at the time of her initial admission on [DATE] did not include specific interventions to meet her needs and prevent the development of a new PU 3) Cross Reference F657: Care Plan Timing and Revision The facility failed to revise R88's CP in a timely manner after she developed a Stage 3 PU on her coccyx.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interview and review of policy, the facility did not follow proper sanitation practices in the kitchen. As a result of this deficiency, there was an increase risk for foodborne illness and quality of service. Findings include: During observation of the kitchen on 02/24/26 at 10:15 AM, a scooper utensil was left in the sugar container. Observation of the kitchen on 02/25/26 at 01:15 PM, Kitchen Staff (KS)1 and KS2 were not wearing hair restraints when working near the food preparation area. Staff interview, on 02/25/26 at 01:20 PM, Dietary Director (DD) acknowledged that the scooper utensil should have been taken out of the container and that the kitchen staff should have been wearing hair restraints at all times. Review of policy on Kitchen Sanitation read; . Policy, standard kitchen guidelines are to be followed as outlined . Procedures, the kitchen should have proper utensil storage and handling . Review of dietary policy on Dress Code read; . Policy, the intent of OPH Dietary Dress Code is for sanitation, safety and to represent the quality of service provided by the Dietary Department. Procedures . effective hair restraints are to be utilized while working in the Dietary Department . Departments should have hairnets, beard guards or bonnets on hand for staff to use. Hair restraint stations are located at each department entrance/exit. Bangs, pony tails should all be restrained under the hat/bonnet/hair net .		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to develop baseline care plans (CP) and update with them to provide effective and person centered care to meet the immediate needs of four Resident's ((R)1, R2, R3,R4) of a sample size of five. As a result of this deficient practice, there is an increase risk of adverse events and lack of continuity of care. This has the potential to affect all new admissions to the facility. Findings include: 1) R1 was a [AGE] year-old female admitted to the facility on [DATE]. Her admitting diagnosis included sepsis (infection), pneumonia, diabetes, hypertension and transient ischemic attack. Reviewed R1's Admission/readmission Observation and Baseline Care Plan (nursing admission assessment) dated 04/02/26. The assessment documented R1 was cognitively impaired. Section N. Musculoskeletal System documented R1 had extreme weakness and required maximal assist from wheelchair to bed upon admission. Question 6. Are siderail(s)/bar(s) in use/requested? was answered Yes. Reviewed R1's admission MDS (minimal data set), dated 04/04/2026. Section GG, Functional Abilities documented she was totally dependent on staff for eating, oral hygiene, toileting hygiene, personal hygiene and rolling from side to side. The Skilled Note by nursing dated 04/02/26 included .On Ceftriaxone (antibiotic) 2 grams IV via PICC (peripherally inserted central catheter, used to deliver medicines directly to large central veins near the heart) line to right upper arm. On 04/20/26 at 10:30 AM, observed R1 in bed, and a noted a portable IV pump at the right side of her bed.On 04/20/26 reviewed R1's CP which revealed the following: Date initiated 04/10/26; The resident has an ADL (activity of daily living) self-care performance deficit. At the time of this review, there were no interventions in the CP to identify what the specific deficits were or how they would be addressed. A second review of the CP on 04/21/26, revealed the interventions for ADLs' was added on 04/21/26. In addition, R1's PICC line was not included in the baseline CP. On 04/21/26, reviewed additional copies of R1's CP that included resolved problems. On 04/03/26 the focus The resident is on antibiotic therapy (ceftriaxone IV) r/t infection: . was initiated with the resolved date of 04/13/26. This did not state R1 had a PICC line that requires specialized care. and monitoring. On 04/21/26 the CP was revised and resolved on the same date to include The presence of PICC line and risk for infection, occlusion, or dislodgment. The goal was PICC line to remain patent, intact, and free from infection or complications throughout duration of its presence. Interventions included: 1) Assess PICC site ., 2). Flush line per facility protocol ., 3). Monitor signs of complications ., and 4). Perform dressing changes per protocol. On 04/21/26 at approximately 10:45 AM, conducted an interview with the infection preventionist in the nursing station. She said they had just gotten an order to discontinue R1's PICC line.On 04/21/26 at 02:30 PM, conducted a phone interview with MDS coordinator (MDSC), who explained the admitting nurse completes the Admission/readmission Observation and Baseline Care Plan, which drives the baseline care plan. She said some of the issues will auto populate the CP, but others would have to be manually put in. The MDSC said she tracks admissions and on day three will look at orders and diagnosis to see if something needs to be added to the CP. She agreed it was important for residents' safety that the level of supervision and assistance needed should be in the baseline CP. 2). R2 was a [AGE] year-old male with a history of coronary artery disease, chronic kidney disease, insulin-dependent type 2 diabetic, spinal stenosis, and left eye blindness. He was admitted to the facility on [DATE] for rehabilitation after being hospitalized for pneumonia, multiple falls, progressive weakness and functional decline. Review of R2's nursing Admission/ readmission and Baseline Care Plan dated 04/09/26 documented he was alert and oriented, had no impairment of upper or lower extremities, amputation to the right great toe and 3rd/4th right toes, with contracture to the left hand. Question 6. Are siderail(s)/bar(s) in use/requested? was answered Yes. Reviewed the Side Rail/Enabler/Grab Bar Observation and Consent dated 04/02/26, which documented the Reason for side rail usage to be assist with transfer (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and bed mobility. On 04/20/26 at 11:00 AM, observed R2 sitting up in bed, and noted enablers attached on both sides. Review of R2's baseline CP revealed it did not include all the information to meet his immediate needs and was not updated as needs were identified in timely manner. The CP did not include 1) the enablers, 2) interventions and level of assistance to meet his ADL self-care performance deficits. The bathing/showering, bed mobility, dressing, eating, personal hygiene and transfer specifics were added 04/21/26, or 3). that he was on insulin. 3) R3 was a [AGE] year-old male with history of diabetes on insulin, coronary artery disease, hypertension, and left below the knee amputation (BKA). He was admitted to the hospital for non-healing stump and osteomyelitis (infection) of the left fibula. He was discharged from the hospital and admitted to the facility on [DATE] for rehabilitation and continued antibiotic therapy. Review of the hospital Discharge summary dated [DATE] revealed R3 was discharged with a PICC line in place and ceftriaxone planned for a six-week course. Review of the Admission/ readmission and Baseline Care Plan revealed R3 to have or requested to have an enabler. On 04/24/26 at 09:00 AM, observed R3 lying in the bed, which had enablers attached on both sides. Reviewed R3's baseline care plan which revealed the PICC line that was present on admission was not added to the CP until 4/22/26. In addition, the enabler was not present in the CP. 4). R4 was a [AGE] year-old male admitted to the facility for rehabilitation on 03/30/26. He had a history of atrial fibrillation on Eliquis (anticoagulant), prior cerebrovascular accident, and diabetes managed with insulin. He was admitted to the hospital following a fall associated with generalized weakness and dizziness and was diagnosed with urinary tract infection. He required moderate assistance for transfers and mobility, and remained at a high risk, so he was discharged from the hospital and admitted for rehabilitation. Reviewed the nursing Admission/readmission Observation and Baseline Care Plan dated 03/30/26, which revealed R4 had or requested an enabler bar. R4's musculoskeletal system assessment documented no impairment to upper extremities, but lower extremity impairment on both sides with extremity weakness. Review of R4's provider orders revealed his orders included: Observe closely for significant side effects of Antidepressant medication (Duloxetine) including drowsiness, blurred vision, dizziness, nausea, fatigue, . Observe closely for significant side effects of Anticoagulant medication (Apixaban) including discolored urine, black tarry stools, nausea or vomiting . On 04/22/26 at 10:00 AM, observed enabler bars on both sides of R4's bed. Reviewed R4's baseline care plan that was initiated on 03/30/26. The baseline CP did not include the high alert anticoagulant or the antidepressant the provider ordered to monitor closely. These were added to the CP on 04/20/26. In addition, the enabler was not added to the CP. 5). On 04/22/26 at approximately 10:00 AM, interviewed and concurrently reviewed the CP's of R1, R2, R3 and R4 with the Director of Nursing (DON) in the conference room. The DON confirmed the baseline CP did not include the items as noted above and that they should have been in the baseline care plan.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, document, record review and interviews, the facility failed to have a policy based on professional standards of practice that addressed the use of enablers (device attached to bedframe that assists the resident with turning, repositioning and getting in and out of bed) to ensure residents are assessed to ensure effective and safe use. Four of a sample size of five Residents (R1, R2, R3, R4) reviewed had enablers attached to the bed. The facility failed to provide evidence of an assessment that included the the Resident's level of cognition and that they understood the use of the enabler to prevent injury. In addition, the consent forms are not signed by the Resident/Representative. r. As a result of this deficient practice, there is increased risk of injury to a Resident with impaired cognition. Findings include: 1) R1 was a [AGE] year old female that was admitted to the facility on [DATE]. Her admitting diagnosis included sepsis (infection), pneumonia, diabetes, hypertension and stroke. Reviewed R1's Admission/readmission Observation and Baseline Care Plan dated 04/02/26, which documented she was cognitively impaired. Section N. Musculoskeletal System documented R1 had extremity weakness and required maximal assist from wheelchair to bed upon admission. Question 6. Are siderail(s)/bar(s) in use/requested? was answered Yes. Reviewed R1's admission MDS (minimal data set), dated 04/04/2026. Section GG, Functional Abilities documented she was totally dependent on staff for eating, oral hygiene, toileting hygiene, personal hygiene and rolling from side to side. Reviewed the Side Rail/Enabler/Grab Bar Observation and consent dated 04/02/26, which documented the reason for usage as bed mobility. On 04/20/26 at 10:30 AM, observed R1 in bed, lying on her back. There were enablers (U shaped) attached to both sides of the bed. R1 was noninterviewable due to her cognitive status. R2 was a [AGE] year old male with a history of coronary artery disease, chronic kidney disease, insulin-dependent type 2 diabetic, spinal stenosis, and left eye blindness. He was admitted to the facility on [DATE] for rehabilitation after being hospitalized for pneumonia, multiple falls, progressive weakness and functional decline. He was incontinent of bowel and bladder and wore briefs. Review of R2's nursing Admission/ readmission and Baseline Care Plan dated 04/09/26 documented he was alert and oriented, had no impairment of upper or lower extremities, amputation to the right great toe and 3rd/4th right toes, with contracture to the left hand. Question 6. Are siderail(s)/bar(s) in use/requested? was answered Yes. Reviewed the Side Rail/Enabler/Grab Bar Observation and Consent dated 04/02/26, which documented the Reason for side rail usage to be assist with transfer and bed mobility. On 04/20/26 at 11:00 AM, observed R2 sitting up in the bed and noted there were enablers attached to both sides of the bed. R3 was a [AGE] year-old male with history of diabetes on insulin, coronary artery disease, hypertension, and left below the knee amputation (BKA). He was admitted to the hospital for non-healing stump and osteomyelitis (infection) of the left fibula. He was discharged from the hospital and admitted to the facility on [DATE] for rehabilitation and antibiotic therapy on 04/10/26. Review R3's nursing Admission/ readmission and Baseline Care Plan documented he was alert and oriented, no impairment of the upper extremities and had the left BKA. Question 6. Are side rail(s)/enable bar(s) in use/requested? was answered Yes. Reviewed the Side Rail/Enabler/Grab Bar Observation and Consent dated 04/10/26, which documented the Reason for side rail usage to be assist with transfer and bed mobility. On 04/24/26 at 09:00 AM, observed R3 lying in the bed and noted enablers attached to both sides of the bed. R4 was a [AGE] year old male admitted to the facility for rehabilitation on 03/30/26. He had a history of multiple falls. The Admission/readmission Observation and Baseline Care Plan dated 03/30/26 documented R4 to disoriented- Some spheres some of the time and memory to be Impaired. R4's musculoskeletal system assessment documented no impairment to upper extremities, but tower extremity impairment on both sides with extremity weakness. Question 6. Are side rail(s)/enable bar(s) in use/requested? was (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	answered Yes. The Nursing admission summary dated [DATE] at 10:50 PM documented R4 had received physical therapy (PT) once before he was discharged from the hospital and was able to get up to use a front wheel walker with moderate assistance. The note included Rehab request note inputted in Rehab mailbox for PT/T evaluation as well as a grab bar request. On 04/22/26 at 10:00 AM, observed enabler bars on both sides of R4's bed. 2) Reviewed the Facility form titled NSG (nursing): Side Rail/Enabler/Grab Bar Observation and Consent. The form was a template filled out by the nurse, and included:1) if a physician order is required? (only required if considered a restraint). 2). Medical symptoms requiring use of rail(s), 3) Are the rails a restraint?, 4) Reason for side rail usage, 5) Types of rails to be used, 6) Frequency of use, 6a) Detail frequency of use 7). Reason for observation. 8). Risks and benefits were explained to resident/family, including the risk of significant injury if a fall occurs. 9). Date the risk/benefits were explained. 10.) Full name of person(s) to whom they were explained. 11). Informed consent.: Resident/family signature. 11a). Informed consent date 12). Nurse signature and date, 13). Clinical Review indicates, and 14). Notification Details. The consent forms for the use of the enabler for R1, R2, R3 and R4 had the Resident/Representative names typed in the designated area for signature, but did not have a signature.3) On 04/21/26 at 02:30 PM, interviewed Registered Nurse (RN)1, who admitted R1 on 04/02/26. She confirmed she did the admission for R1 and that after she did her Assessment, she filled out a request for Physical therapy for the enabler. Asked if the facility required an order for enabler, and she said no. On 04/21/26, at 03:30 PM interviewed the Director of Nursing and the Administrator (ADM). The ADM said the facility did not have a restraint policy because they do not use restraints. Inquired if there was a policy or criteria for the use of enablers, and she said no. 4) To ensure safe and effective use of enablers there must be a policy with clear guidelines outlining the purpose and use of enablers. The policy should include assessment of the residents cognitive level to determine understanding of the device, documentation in the Resident's care plan and regular reassessment of their needs.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record and document review, the facility failed to develop and implement a discharge plan for the transition of post discharge care for one Resident (R)107 of a sample size of three. R107 had an indwelling urinary catheter (a medical device that helps drain urine from your bladder) at the time of discharge. The facility was not able to provide evidence that the Care Giver (CG) had the capacity, capability, or received education on how to preform catheter care. As a result of this deficient practice, there was increased risk of infection and complications related to the urinary catheter. This deficient practice could affect any discharged resident if the CG is not properly trained and capable to provide the after care needed. Findings include: On 12/10/25, the Office of Health Care Assurance received a report of concern that R107 did not have the resources needed after discharged home from the facility. It was reported that R107's CG could not safely manage the urinary catheter, which put her at increased risk of developing a urinary tract infection. R107 was a [AGE] year-old female admitted to the facility for short term rehabilitation due to generalized weakness on 08/26/25 after an acute care hospitalization. Prior to being hospitalized, she lived with her son, who was her support person and assisted her with her needs. R107's medical history included diabetes, spinal stenosis, chronic back pain, muscle weakness and abnormalities in gait and mobility. She had end stage renal disease and on dialysis. R107 was cognitively intact, was able to walk using a front wheel walker with CG assist and was totally dependent on staff (two-person assist) for transfers, requiring a mechanical lift (equipment used to transfer patients safely). While at the facility, she developed urinary retention and required an indwelling urinary catheter. The urinary catheter was not removed and was in place when she went home. R107 was discharged home on [DATE] with her son, who was the designated CG. Reviewed R107's nursing progress note dated 11/23/25 at 13:21, which included Resident discharged home with son, to be followed up by primary care provider as well as have home health services provided.son at bedside during dc (discharge) process. Resident transferred to son's car with staff assist. Per resident and resident's son will be able to transfer her out of vehicle upon arriving home.Education/Training Response as indicated: n/a.(not applicable) . There was no documentation that the CG was educated to manage the care of the Foley. On 02/27/26 at 11:00 AM, interviewed the Social Services Assistant (SSA), who reviewed R107's notes and contacted the Social Worker (SW) by telephone to inquire about the CG training. The SW said the vendor that delivers the mechanical lift does the CG training when they bring the equipment to the home, but he did not know if nursing provided the education on catheter care. He said the son had taken care of R107 prior to being hospitalized, but acknowledged R107 did not have a urinary catheter at home, prior to admission to the facility. On 02/27/26 at 12:30 PM, during an interview with the Administrator, she confirmed it was nursing's responsibility to assess what training the CG needed, provide and document the training. In addition, they should document the CG was willing, capable and had the capacity to provide the care to ensure the Resident's needs will be met. The facility failed to provide evidence of the CG training on Foley care.		

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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, record reviews, and interviews, the facility failed to develop and implement a comprehensive person-centered care plan for four of 21 residents (Resident (R) 6, 9, 88 and 104) in the active sample. As a result of this deficient practice, these residents were placed at risk for a decline in their quality of life, and were prevented from attaining their highest practicable physical, mental, and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) R88 is an [AGE] year-old female that was a long term resident at the facility with initial admission [DATE]. She had a medical history that included Guillain-Barre syndrome (GBS), paraplegia, spinal stenosis, neurogenic bladder and was cognitively impaired. On 02/03/26, R88 was sent to the hospital for respiratory distress and admitted with diagnosis of Saddle embolus of pulmonary artery (life threatening condition where large blood lodges at the bifurcation of the main pulmonary artery, blocking blood flow to both lungs), bilateral pulmonary emboli and bilateral femoral deep vein thromboses. She was discharged from the hospital and readmitted to the facility on [DATE]. On 02/26/2026 at 12:11 PM, observed two family members (FM)'s of R88 in the hallway outside Resident's room talking to a staff member. Overheard a FM say R88 had not been turned in 3 days. Conducted an interview with FMs at that time. FM1 said they (FM1 and FM2) had been at the facility from 08:00 AM to 08:00 PM the past three days, and the staff never turned R88 the entire time. FM1 said she was very concerned because R88 had recently been in the hospital for blood clots and also had a pressure ulcer (PU). She went on to say they reported their concern to the Certified Nurse Aide (CNA) on duty 02/25/26, who agreed it was their responsibility to position her and that it should be done. FM1 also said the CNAs told her that R88's PU was getting bigger. Reviewed R88's Care Plan (CP) that which revealed the following: On 01/18/26, the CP focus was initiated: This resident is at risk for new pressure injury development r/t impaired mobility, decreased function, incontinence and MASD (moisture associated skin damage). The interventions included: 1) Follow facility policies/protocol's for the prevention/treatment of skin breakdown. and 2) Obtain and monitor lab/ diagnostic work . Reviewed the policy provided for prevention of PU's titled Skin Management System, effective date 11/07/25, which included 7. Initial interventions will be noted on the Baseline Care Plan as indicated. Ongoing problems and interventions will be captured on the Comprehensive Care Plan if indicated. The policy did not address interventions for prevention of PU's. On 02/27/26 at approximately 10:30 AM, interviewed the Resident Care Manager (RCM) in the nursing station and reviewed R88's CP. The PCM confirmed R88 was high risk for developing a PU, should be positioned and turned frequently, and confirmed the comprehensive care plan did not include specific interventions for prevention. She also confirmed that R88 has been immobile and was totally dependent on staff for positioning since her initial admission. 2) R104 was admitted to the facility on [DATE]. His medical diagnosis included history of traumatic brain Injury, constipation, and sepsis. He was incontinent of bowel and bladder, had limited physical mobility and required partial/moderate to substantial maximum assist for activities of daily living (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Legacy Hilo Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 563 Kaumana Drive Hilo, HI 96720	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(ADL's). R104 had a pressure ulcer to his right heel and wound to right foot. On 02/25/2026 at 11:58 AM, observed R104, in bed with just a diaper on. He had a dressing on his right foot and noted to have lower leg contractures. Observed protective foot boot in the corner of the room. Attempted to interview R104, but he would not answer simple questions and started to get agitated and move about the bed, so the interview was stopped On 02/25/26, reviewed R104's CP, which included he had actual impairment to skin integrity that included a pressure ulcer to the right heel and wound to right foot. The intervention for the wounds included: heel protectors to RLE (right lower extremity) while in bed/wheelchair. On 02/27/26 at approximately 01:15 PM, interviewed RCM, who confirmed that R104's care plan included heel protector to the right lower extremity. Reported that R104 had been observed without the boot every morning of the survey while he was in bed (02/24/26, 02/25/26 and 02/26/26). At that time, she said he often refused to wear the boot or kicked it off. The RCM said the CNAs are required to document the application of the boot and any refusals. Reviewed the progress notes and there was no documentation of refusals for the three days. Review of the Treatment Administration Record revealed documentation the boot was applied the day shift of 02/24/26, 02/25/26 and 02/26/26, which did not match actual observations. On 02/27/26 at approximately 01:30 PM, observed R104 in the hallway in a wheelchair with a shoe on the left foot, dressing on right foot, but no protective boot. Although R104's CP included the intervention of application of the boot to prevent further issues with the foot wounds, there was lack of evidence the staff attempted to apply the boot on a consistent basis, document refusals, or address the issue with the provider. 3) On 02/25/26 at 11:30 while interviewing R104's roommate, the roommate said he was very concerned about the staff's safety and said, No one should go in that room alone and care for him (R104) because of his behaviors. Review of R104's CP revealed it did not include any issue (Focus) of negative behaviors. The CP included an intervention/task to Monitor/document side effects of pain medication. Observe for. increased agitation, restlessness, confusion, hallucinations .Report occurrences to the physician. On 02/26/26 at approximately 11:30 AM, observed the Infection Preventionist (IP) prepare and perform the dressing change of R104's foot wound. While preparing supplies outside the room, she asked the RCM, who was going to assist to go into the room and clean the water off the overbed table because he had thrown water earlier in the day. At that time, asked the IP if R104 had known negative behaviors, and she replied yes, he throws stuff at people. On 2/26/26 at 01:45 PM, interviewed the CNA, who was assigned to R104. She said he became very agitated when she was in the room earlier, so she left and came back later. The CNA said, he has these behaviors now and then. Inquired if the CNA's document when the behaviors occur, and she said no. Reviewed R104's nursing progress notes that included the following entries of negative behaviors: 02/04/26 alert note resident expressing need to leave again and having behaviors at staff. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/07/26 at 22:42, Behavior notes: Resident having negative behaviors toward staff and his neighbor. Resident was counseled and responded with more behaviors. Will continue with plan of care. On 02/27/26, a second record review revealed R104's CP was revised 2/26 to add The resident has a behavior problem of throwing items at staff. The interventions/tasks did not include monitoring the specific type of behaviors or how often they occurred. 4) R6 was a [AGE] year-old resident admitted to the facility for short-term rehabilitation services. Diagnoses included but not limited to atrial fibrillation (fast, irregular heart rhythm that causes blood to pool and increasing the risk for blood clots and stroke), history of transient ischemic attack (mini stroke) and cerebral infarction (medical condition caused by blockage of blood flow to the brain). On 02/25/26 at 11:20AM, an interview was conducted with R6 in his room. During the interview, observed some dried-up blood stains on the right side of his bed sheets. R6 said he has a small cut on his elbow but does not know how he got it and added that he is clumsy and bumps into things sometimes. Asked R6 if was taking anticoagulants to which he said, I've been on them (anticoagulants) for a long time. Review of R6's Electronic Health Record (EHR) revealed he was on Apixaban (an anticoagulant, medication that prevents or reduces the formation of clots) 5 mg (milligrams) twice a day. Review of current care plan revealed there were no plans or interventions related to R6's use of anticoagulants. 5) R9 was a [AGE] year-old resident admitted to the facility on [DATE] for short-term rehabilitation services. Diagnoses included but not limited to acute embolism and thrombosis of left femoral vein and history of falls. On 02/25/26 at 10:10 AM, an interview was conducted with R9 in her room. Observed old bruises on her right wrist and top of right hand. R9 said she has been taking anticoagulants for many years now. Review of R9's EHR revealed an order for Apixaban 5 mg twice a day, however, current care plan did not include care and interventions related to the use of anticoagulants. On 02/27/26 at 08:48 AM, a concurrent interview and record review was conducted with RN11 at the nurses' station. Reviewed current comprehensive care plans for both R6 and R9 with RN11 and confirmed there was no care plan to address the use of anticoagulants for both residents. RN11 added that a care plan should have been developed for both since they were admitted with an order for the anticoagulant.		

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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 interviews, observations and record/document review, the facility failed to ensure that the comprehensive care plan was reviewed and revised in a timely manner to reflect the current condition of two residents (R)2 and R88 of a sample size of three. As a result of this deficient practice, the care team does not have the current information needed to care for the resident's to ensure they reach their highest potential. Finding's include: 1) R2 was a long-term resident at the facility and requires 24-hour care. His medical history included End Stage Renal Disease requiring hemodialysis, Diabetes Type 2, Congestive Heart Failure, and stroke with left side weakness. He is dependent on staff for all Activities of Daily Living (ADL) and is a two-person transfer. On 02/25/26 at 08:10 AM, observed R2 in bed. He appeared comfortable and breathing easily. R2 was non interviewable. There was no sign outside the door that indicated R2 was on Droplet/Contact precautions. Record Review of R2's active care plan (CP) revealed he was on COVID Isolation Precautions R/T (related to) COVID + (positive for COVID infection). Interventions included: antiviral therapy if indicated, assist resident with donning mask as necessary, clarify orders for aerosol medications if indicated, complete symptom specific assessment as indicated, Evaluate for potential to be affected by the limited visitation ., Follow CDC (Center for Disease Control) protocol to obtain orders to start and start and discontinue transmission-based precautions. Special Droplet/Contact Precautions (full PPE with N95 mask and shield). On 02/27/26 at 08:25 AM, interviewed the Resident Care Manager (RCM) in the nursing station. When inquired if R2 had an active covid infection, she said he was diagnosed with a COVID infection on 10/03/25 but did not currently have COVID. At that time, reviewed R2's CP with the RCM and she acknowledged it was not accurate and should be updated. 2) R88 was an [AGE] year-old female that was a long term resident at the facility with initial admission [DATE]. She had a medical history that included Guillain-Barre syndrome (GBS), paraplegia, spinal stenosis, neurogenic bladder and was cognitively impaired. On 02/03/26, R88 was sent to the hospital for respiratory distress and when discharged from the hospital and readmitted to the facility on [DATE]. Due to her immobility, R88 was a high risk for developing Pressure Ulcer (PU). Review of R88's medical records revealed the following: admission (readmission) Summary dated 02/12/26, included R88 had MASD (moisture associated skin damage) to buttocks, zinc oxide cream applied during brief change. There was no PU noted at this time. Nursing note on 02/20/26, at 13:42, included Resident had skin breakdown to her coccyx area discovered during nurse management skin rounds. Resident with a Stage 111 (3) . orders entered. Reviewed R88's CP which revealed the CP was not revised to address the Stage 3 PU with interventions in a timely manner, and was not updated until 02/24/26. On 02/27/26 at approximately 10:30 AM, interviewed the RCM in the nursing station and reviewed R88's CP. The RCM confirmed she made the revisions to R88's CP on 02/24/26 to address the new Stage 3 PU to her coccyx after she did wound rounds with the external Wound Care Team.		

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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. Based on observation and interview the facility failed to ensure one of three residents (Resident (R) 62) sampled was free from accident hazards as evidenced by over the counter (OTC) medication, brought in by Family Member (FM)3, being stored in R62's room and administered by FM3 without notifying staff. This deficient practice created a risk for injury to R62 due to inappropriate and unsafe administration of the OTC medications by an unauthorized person. Findings include: On 02/24/26 at 10:46 AM, a bottle of Tussin Cough and Chest Congestion liquid and a bottle of Tylenol Extra Strength 500mg capsules were observed on R62's corner table. On 02/25/26 at 09:03 AM, FM3 was interviewed in R62's room. The bottles of Tussin and Tylenol Extra strength remained on the corner table. FM3 stated that he brought in the two medications, and while R62 has been in the facility, FM3 stated he had given the Tussin to R62 a couple times, approximately six months to a year ago, and Tylenol Extra Strength, the last time being six to eight months ago because R62 looked uncomfortable sitting in the chair. FM3 stated that he did not inform the Nurse that he gave these medications. On 02/26/26 at 03:30 PM, the Resident Care Manager (RCM)2 verified the Tussin and Tylenol Extra Strength bottles on the corner table in R62's room. RCM2 stated that medications should not have been stored in the resident's room unless the resident was assessed to be able to self-administer and the medications would need to be kept in a locked box. RCM2 stated that R62 was not a candidate for medication self-administration. On 02/27/26 at 10:27 AM, the Director of Nursing (DON) was interviewed and stated that the only reason medications could be stored in a resident's room is if the resident was assessed that he/she could self-administer medications safely and the medications would need to be locked.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that two of 21 residents (Resident (R) 74 and R109) in the active sample were free from significant medication errors as evidenced by R74 being administered an inappropriate dose of short acting insulin via insulin pen and R109 was administered an insulin dosage via insulin pen based on a blood sugar taken after a meal. As a result of this deficient practice, R74's and R109's health and safety were jeopardized. Findings include: 1) On 02/06/26 at 08:03 AM, Licensed Practical Nurse (LPN) 4 was observed preparing medication for R74 at the medication cart on the Kamakau unit. Reading from the Medication Administration Record (MAR), LPN4 stated R74 was due for 15 units of Lantus insulin via pen and results of blood sugar fingerstick taken at 06:51 AM was 143 mg/dl (milligram/deciliter). LPN4 proceeded to remove the insulin pen from the medication cart drawer, compared the label on the insulin pen to the MAR, and prepared the insulin pen to 15 units. LPN4 then asked the Infection Preventionist (IP) to double check the amount that was set on the pen. The IP asked how many units was to be given and LPN4 stated 15 units. The IP looked at the pen and confirmed it was set to 15 units. Upon returning to the medication cart after administering the insulin to R74, LPN4 stated that 15 units of Novolog 100u/ml flex pen was given to R74 instead of the Lantus. An order for sliding scale was noted on R74's MAR and based on the blood sugar result of 143 mg/dl, the Novolog insulin was to be held (Blood sugar 70-150 = 0 units). On 02/26/26 at 09:15 AM, LPN4 was interviewed on Lehua [NAME] unit and stated that the Nurse Practitioner (NP), who was at the facility, was notified and ordered recheck R74's blood sugar in one hour from the administration time and monitor for signs and symptoms of hypoglycemia. LPN4 stated that he did match the insulin pen to the order noted on the MAR but did not realize that the wrong insulin was provided to R74 until after it was administered. At 09:20 AM, LPN4 was observed rechecking R74's blood sugar via fingerstick with a result of 216 mg/dl and assessed R74 for signs of hypoglycemia. On 02/26/2026 11:55 AM, LPN4 was interviewed and stated that at 11:32 AM, R74 was assessed and displayed no signs of hypoglycemia and blood sugar was checked with a result of 118 mg/dl. On 02/27/26 at 08:50 AM, a review of R74's progress notes and February 2026 MAR, noted R74's blood sugar fingerstick was retaken on 02/26/26 at 01:16 PM with a result of 120 mg/dl and on 02/26/26 at 05:06 PM with a result of 172 mg/dl. No events of hypoglycemic episodes were documented for R74. A facility policy titled, Medication Administration General Guidelines with a date of 2007, stated, . Medication Preparation: .9. Verify medication is correct three (3) times before administering the medication. a. When pulling medication package from med cart, b. When dose is prepared, c. Before dose is administered. 2) On 02/25/26 at 11:23 AM, R109's Family Member (FM) 5 was interviewed in the courtyard. FM5 stated that on 02/23/26 after R109 ate lunch and close to 01:00 PM, she went into the hallway from R109's room and informed LPN6 that R109 needed his folder for dialysis, lunch time medication, and his sugar checked. FM5 stated that LPN6 responded that R109 was going to dialysis and did not need the lunch medication, checked R109's blood sugar and gave insulin in the hallway. On 02/26/26 at 12:00 PM, LPN6 was interviewed in the Kamakua Unit. LPN6 stated that on 02/23/26, she was dealing with another resident emergency and did not get to pass her lunch medications as scheduled but could have asked for assistance from other facility licensed nurses. LPN6 confirmed the following: -R109's blood sugar fingerstick was done after he ate lunch with a result of 254mg/dl (milligrams/deciliter). Insulin was given per ordered sliding scale right before R109 left for dialysis. R109's February 2026 MAR documented Insulin Aspart 100 units/ml 6 units was given per sliding scale (241 -300 = 6 units). -R109's lunchtime oral medication was not given and documented on the Medication Administration Record (MAR) that it was not given. -LPN6 verbalized that she should have informed R109's physician's that the blood sugar was taken after lunch was eaten, insulin was given based on that blood sugar result, and R109's oral lunch medication was held. On 02/27/26 at 08:55 AM, R109's (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician Orders and February 2026 MAR were reviewed. A physician's order dated, 02/10/26 stated, Blood Glucose Monitoring before meals and at bedtime. A physician's order dated 02/10/26 stated, Calcium Acetate (Phos binder) Oral Capsule 667mg [milligrams].Give 3 capsule by mouth with meals. and scheduled for 1130. The entry for 02/23/26 was marked on the MAR by LPN6 with a code of 1. The legend on the MAR stated, 1 = Absent from home without meds however, the resident was still in the facility as evidenced by R109 being administered insulin by LPN6 before leaving for dialysis.A facility policy titled, Medication Administration General Guidelines, with a date of 2007, stated, . Medication Administration: 14. Medications are administered within 60 minutes of scheduled time .		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure all medications used in the facility were labeled in accordance with professional standards. Proper labeling of medications is necessary to promote safe administration practices, decrease the risk for medication errors, and decrease the risk for the diversion of resident medications. This deficient practice has the potential to affect all residents in the facility who take medications. Findings include: On 02/25/26 at 02:18 PM, inspection of the [NAME] Unit medication cart was conducted with Registered Nurse (RN)6. Observed an eye drop medication in a plastic bag with a label that stated, Refrigerate until opened. Discard 42 days after opening. Date opened: _____ (blank). Queried RN6 if the medication was currently being used and considered open. RN6 said, This is not my regular unit, so I'll check with the other nurse. RN6 asked RN11 and confirmed that the medication was currently being used and added that they would not know when it has been open for 42 days since the open date was not noted on the label.		