STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leahi Hospital	3675 Kilauea Avenue Honolulu, HI 96816

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 35314 Based on record review, interview, and facility policy review, the facility failed to refer residents with newly evident or possible serious mental disorder, intellectual disorder, or related condition, to the state-designated mental health or intellectual disability authority for review. The deficiency affected 2 (Resident #9 and Resident #39) of 2 residents reviewed for Pre-Admission Screening and Resident Review (PASARR; PASRR) services. Findings included: A facility policy titled, Preadmission Screening Resident Review (PASRR), dated 06/07/2018, revealed the section titled II. Policy, included, E. Social Services will be contacted for assistance with Level II evaluations and for any significant mood or behavior changes that may necessitate a Level II evaluation at any time throughout the resident's stay at [the facility]. The policy revealed the section titled, IV. Procedure, included, C. Nursing Supervisor, Unit Manager and Social Worker will review PASRR for Part C exceptions for individuals with MI [mental illness] or ID [intellectual disability]/DD [developmental disability] (i.e. [id est; that is], physician certification for less than 30 day stay that is required for condition which they were hospitalized for); and will follow up within the accepted time frame if additional action is necessary, such as Level I re-evaluation and Level II evaluations and appropriate review by the state agencies. Further review revealed, I. When observing any significant decline in mood and behavior in a resident with SMI [serious mental illness], IDT [interdisciplinary team] will determine if a significant change minimum data set (MDS) assessment is warranted. Care plan(s) will be revised, if appropriate. If the resident does not stabilize within 21 days, Level II evaluation will be initiated and submitted to AMHD [Adult Mental Health Division] through the ePASRR [electronic PASRR] website. 1. An Admission Record indicated the facility admitted Resident #9 on 06/15/2004. According to the Admission Record, Resident #9 had a medical history that included a diagnosis of psychotic disorder (onset 10/03/2017). Resident #9's Preadmission Screening Resident Review (PASARR) Level I Screen, dated 05/15/2004, revealed the resident did not have a mental disorder, which included psychotic disorder. A quarterly MDS, with an Assessment Reference Date (ARD) of 07/02/2024, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #9 had an active diagnosis of psychotic disorder. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leahi Hospital	3675 Kilauea Avenue Honolulu, HI 96816

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #9's medical record revealed no evidence that indicated a referral was made to the appropriate state-designated authority after the resident's diagnosis of psychotic disorder. 2. An Admission Record indicated the facility admitted Resident #39 on 06/06/2017. According to the Admission Record, Resident #39 had medical history that included diagnoses of delusional disorders (onset 08/09/2018) and paranoid personality disorder (onset 08/09/2018). Resident #39's Preadmission Screening Resident Review (PASARR) Level I Screen, signed by a physician on 06/06/2017, revealed the resident did not have a serious mental illness, such as psychotic disorder or delusional (paranoid) disorder. A quarterly MDS, with an Assessment Reference Date (ARD) of 07/02/2024, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #39 had active diagnoses of psychotic disorder other than schizophrenia and paranoid personality disorder. Resident #39's medical record revealed no evidence that indicated a referral was made to the appropriate state-designated authority after the resident's diagnosis of psychotic disorder. During an interview on 08/01/2024 at 8:10 AM, the Director of Nursing (DON) stated the facility did not update Level I PASARRs after the residents had been admitted to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leahi Hospital	3675 Kilauea Avenue Honolulu, HI 96816

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 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** 40141 Based on observation, interview, and facility policy review, the facility failed to ensure medication carts were locked when not within the line of sight of facility staff for 2 of 6 medication carts. Findings included: A facility policy titled, MEDICATION: Unit Storage; Expiration Dating; Inspection, dated 03/02/2005, specified, All medications/medication storage areas are locked when not observed by nurses. During an observation on 07/30/2024 at 11:31 AM, upon entrance to unit Young 4, a medication cart (Team 2 cart) was located between room [ROOM NUMBER] and room [ROOM NUMBER] and was not locked. There was no staff in the hallway. At 11:32 AM, Registered Nurse (RN) #2 exited room [ROOM NUMBER] and stated the medication cart should have been locked because it was out of her line of sight. During a concurrent interview RN #2 said the medication cart should have been locked when she walked away for medication safety. Some of the medications observed in the cart included lisinopril (used to treat high blood pressure), metoprolol (used to treat high blood pressure), trazodone (an antidepressant), Remeron (an antidepressant), Coumadin (an anticoagulant), Buspar (anti-anxiety), and insulin syringes. During an observation on 07/30/2024 at 1:29 PM, upon entrance to unit Young 5, a medication cart (Team 2 cart) was between room [ROOM NUMBER] and room [ROOM NUMBER] and was not locked. RN #3 exited room [ROOM NUMBER] and stated the medication cart should always be locked. During a concurrent interview RN #3 stated she was in a rush to administer medications to a resident but should not have left the medication cart unlocked. RN #3 stated the medication cart should be locked because there were medications inside and if it was unattended then it should be locked. Some of the medications observed in the cart included citalopram (an antidepressant), Depakote (an anticonvulsant), Seroquel (an antipsychotic), metoprolol tartrate (used to treat high blood pressure), levetiracetam liquid (an anticonvulsant) and insulin syringes. During an interview on 07/30/2024 at 3:47 PM, the Director of Nursing (DON) stated if the nurse left the medication cart that it should be locked. During an interview on 07/31/2024 at 10:45 AM, RN #5 stated if a medication cart was not attended then it should be locked. During an interview on 07/31/2024 at 10:58 AM, RN #1 stated if the medication cart was not visible to the nurse, then it should be locked. During an interview on 08/01/2024 at 8:41 AM, the DON stated she expected for staff to lock the medication cart if the cart would be left unattended. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leahi Hospital	3675 Kilauea Avenue Honolulu, HI 96816

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/01/2024 at 9:29 AM, the Administrator stated she expected for the medication cart to be locked at all times when the nurse was out of sight.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125010	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leahi Hospital	3675 Kilauea Avenue Honolulu, HI 96816

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 35314 Based on interview, record review, facility document review and facility policy review, the facility failed to maintain an effective Quality Assurance and Performance Improvement (QAPI). Specifically, the facility failed to ensure corrective action was implemented and maintained to ensure sustained compliance with reporting and investigating alleged allegations of abuse. This had the potential to affect all residents that resided in the facility. Findings included: The Department of Health and Human Services Center for Medicare and Medicaid Services [CMS] Form CMS-2567's, dated 09/20/2021, 09/30/2022, and 09/14/2023, revealed the facility received deficiencies for F609 and F610 each year. The facility's Quality Assurance & Performance Improvement (QAPI) Plan 2023-2024, reviewed by the facility on 07/21/2022, revealed, Decisions will be made to promote excellence in quality of care, resident choice, person directed care, and resident transitions. Focus area will include systems that affect resident and family satisfactions, quality of care, and services provided, and all areas that affect the quality of life for persons living and working in our organization. The plan also indicated, The QAPIC [Quality Assessment and Performance Improvement Committee] has the responsibility to -Review quality improvement reports on identified quality deficiencies, such as survey findings, develop appropriate plans of action to correct identified and confirmed quality concerns, implement the plans of action, monitor the effectiveness of action plans and make revisions as needed. The plan revealed Attachment G included a Performance Improvement Project (PIP) Inventory with dates of review of 11/01/2018, 02/07/2019, 03/2020, 07/2021, and 05/2023. Further review revealed the inventory did not indicate there was a PIP for the area of abuse reporting and investigating. The plan revealed Attachment H included a Performance Improvement Project (PIP) Inventory with a date of review of 05/12/2022. Further review revealed the inventory did not indicate there was a PIP for the area of abuse reporting and investigating. During an interview on 08/01/2024 at 1:16 PM, the Director of Nursing (DON) said that all abuse allegations were discussed during the QAPI meetings, but it was not discussed whether the investigations were completed per the facility's abuse policy. During an interview on 08/01/2024 at 2:31 PM, the Quality Assurance (QA) Coordinator stated the facility QAPI plan was not effective if the facility was being cited for the same concerns each survey.