

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 10/25/2024
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.

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observations, resident interview, staff interview, and review of policy, the facility did not have the call bell in reach for one Resident (R)14 out of six Residents sampled. As a result of this deficiency, R14s ability to call out for help was limited and the deficient practice has the potential to affect all the residents that uses the call bell for assistance.</p> <p>Findings Include:</p> <p>During observation and interview on 10/22/24 at 10:18 AM, R14's call bell was attached to the bed but was dangling and out of reach. R14 said that he/she had hard time finding the call bell to call out to staff.</p> <p>Observation and interview on 10/23/24 at 02:30 PM, R14's call bell was dangling over head of the bed and out of reach. R14 wanted to call to ask staff a question.</p> <p>Observation on 10/25/24 at 09:22 AM, R14 was sitting in a wheelchair next to the bed and the call bell was out of reach, dangling from the bed rail. R14 was trying to get the attention of staff.</p> <p>Staff interview on 10/23/24 at 02:51 PM, Certified Nurse Assistant (CNA)4 acknowledged that the call bell was out of reach and moved it closer to the resident.</p> <p>Review of policy on Call Light use read; Purpose, to respond promptly to resident's call for assistance, to ensure call system is in proper working order. Procedure, all facility personnel must be aware of call lights at all times . When providing care to guest/resident, be sure to position the call light conveniently for the resident to use, tell the guest/resident where the call light is and show him/her how to use the call light . Be sure all call lights are placed on the bed at all times, never on the floor or bedside stand or clipped to the guest/resident or placed in reach when sitting up .</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on interviews and record review, the facility failed to exercise reasonable care for the protection of the property from loss or theft for one out of 22 sampled residents (Resident (R) 9). As a result of this deficiency, R9's psychosocial wellbeing was negatively affected. R9 did not think the facility took his statement seriously. This deficient practice has the potential to affect all the residents whose property is lost or missing.</p> <p>Findings Include:</p> <p>Interview was conducted with R9 on 10/22/24 at 01:45 PM in his room. R9 stated that a couple of months ago, five bottles of supplements went missing after taking just one pill. R9 explained that a family member had ordered the supplements for him and had it delivered to the facility. R9 had informed a couple of the facility staff of the missing items and staff had helped him search for it. R9 was not sure if the staff had taken his statement seriously. R9 did not think the facility had opened an investigation regarding his missing items because no one had spoken to him regarding the missing bottles.</p> <p>Interview was conducted with R9's family member by phone on 10/24/24 at 01:19 PM. R9's family member confirmed that he had ordered 5 bottles of supplements for R9 two months ago and had it delivered to the facility.</p> <p>Interview was conducted with Registered Nurse (RN) 10 on 10/24/24 at 01:27 PM at the nurse's station. RN10 stated that R9 had informed her of his missing supplements a couple of months ago and RN10 searched for it with other staff. RN10 was not sure if the facility social worker was aware of R9's missing items. RN10 did not inform the social worker that R9 was missing his supplements.</p> <p>Interview was conducted with Social Worker (SW) 1 on 10/24/24 at 01:29 PM at the nurse's station. SW1 stated that once a resident's item is reported missing, staff begins a search for it. If the item is not found, the facility fills out a lost item form and begins the investigation process. SW1 confirmed that she was not aware that R9 had missing items a couple of months ago. Therefore, investigation for R9's items was not started.</p> <p>A review of the facility policy titled, Theft and Loss Program, last updated on 01/01/2010, was conducted on 10/25/24. The policy noted, 8. If a resident, responsible party or staff member become aware that an item is missing, they will initiate a theft and loss form and forward immediately to Social Services.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and Record Review (RR), the facility failed to ensure a copy of the notice of transfer or discharge was sent to a representative of the Office of the State Long-Term Care Ombudsman for four residents (Resident (R)41, R57, R35, and R56) sampled. Requested a copy of the sampled resident's transfer or discharge notice that was sent to a representative of the Office of the State Long-Term Care Ombudsman and the Administrator confirmed the facility has not been sending any copies of the notices to the Ombudsman. This deficient practice has the potential to affect all the residents who are transferred or discharged from the facility.</p> <p>Findings Include:</p> <p>1) On 10/23/24 at 11:04 AM during interview with R41 he stated he went to the hospital this year to have my leg amputated.</p> <p>On 10/23/24 at 3:00 PM requested notice of transfer or discharge, bed hold and ombudsman notification for R41 from Administrator.</p> <p>Administrator provided a copy of the Notice of Transfer/Discharge for R41 on 10/24/24. Two copies were given, one was dated 05/31/24 and 06/24/24 and both included the bed hold policy.</p> <p>2) On 10/23/24 during RR of R57's Electronic Health Record (EHR) found R57 was sent to the hospital on [DATE] after a fall and admitted to the hospital for a diagnosis of fall with left inferior pubic ramus fracture.</p> <p>On 10/23/24 at 3:35 PM requested notice of transfer or discharge, bed hold and ombudsman notification for R57 from the Administrator. Also requested facility policy for transfer and discharge.</p> <p>On 10/24/24 at 11:07 AM received Notice of Discharge/Transfer and bed hold form that was signed by R57 on 10/23/24. Resident returned to facility on 10/23/24 from the hospital and was re-admitted to the facility. Awaiting copy of notification was given to Ombudsman from Administrator for R41 and 57. Administrator was able to provide a copy of the Transfer or Discharge Policy (Including AMA) which was last updated 10/22/2022.</p> <p>On 10/24/24 at 11:25 AM Administrator came to conference room to notify surveyor that the facility staff have not been sending copies of the notice of resident discharge/transfer to the Ombudsman.</p> <p>3) Reviewed R35's EHR which documented the resident was discharged to an acute hospital on [DATE]. R35's EHR did not contain documentation of the facility's notification to a representative of the Office of the State Long-Term Care Ombudsman of R35's discharge.</p> <p>Requested documentation of the facility's notification to the Ombudsman for R35's discharge. On 10/24/24 at 01:07 PM, the Administrator confirmed a notice of transfer/discharge was not sent to the Ombudsman and a notice should have been sent.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>4) Reviewed R56's EHR which documented the resident was discharged to an acute hospital on [DATE]. R56's EHR did not contain documentation of the facility's notification to the Ombudsman of R56's discharge.</p> <p>Requested documentation of the facility's notification to the Ombudsman for R56's discharge. On 10/24/24 at 01:07 PM, the Administrator confirmed a notice of transfer/discharge was not sent to a representative of the Office of the State Long-Term Care Ombudsman and a notice should have been sent.</p> <p>Review of the facility policy Transfer or Discharge Policy (Including AMA) which was last updated 10/22/2022, states Policy Interpretation and Implementation 6. Generally, the notice must be provided at least 30 days prior to a facility- initiated transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is effected because: a. The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident; b. The resident's health improves sufficiently to allow a more immediate transfer or discharge; c. An immediate transfer or discharge is required by the resident's urgent medical needs; or d. A resident has not resided in the facility for 30 days. In these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, and LTC ombudsman as soon as practicable before the transfer or discharge.</p> <p>7. The facility will maintain evidence that the notice was sent to the Ombudsman as applicable.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one out of 22 sampled residents (Resident (R) 66). R66 experienced frequent pain and the facility failed to develop a care plan for R66's pain. The deficient practice has the potential to negatively affect R66's wellbeing and has the potential to affect all the residents who experiences pain in the facility.</p> <p>Findings Include:</p> <p>R66 is a [AGE] year-old female admitted to the facility on [DATE]. R66 has medical diagnosis that includes, but not limited to, hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side, aphasia, low back pain, and pain.</p> <p>Observation and interview were conducted with R66 on 10/23/24 at 09:53 AM in R66's room. R66 was observed rubbing/massaging her left thigh area. R66 stated that she experiences constant pain in her left thigh area and needs to take medications for it.</p> <p>A review of R66's Minimum Data Set (MDS) dated [DATE] was conducted. Section J in R66's MDS noted that R66 has frequent pain.</p> <p>A review of R66's current care plan was conducted on 10/23/24. R66's care plan did not include a plan of care for her frequent pain.</p> <p>Interview was conducted with the Director of Nursing (DON) on 10/24/24 at 10:35 AM in the DON's office. DON confirmed that R66 had frequent pain and was aware that R66 takes medications to alleviate the pain. DON confirmed that R66 should have had a care plan for pain.</p> <p>A review of the facility policy titled, Pain Management Policy, with a revision date 07/12/2023, was conducted. The policy noted, 3. An individualized Care Plan will be developed to identify a resident's pain and interventions to assist with care of the resident and updated with any changes in interventions.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and Record Review (RR) the facility failed to assure one of the sampled residents (Resident (R) 132) received appropriate treatment and services with care for his urinary indwelling catheter. The deficient practice included R132's urinary catheter tubing being left on the ground, urinary catheter flush for blood in the tubing performed by licensed staff without a physician order, and licensed staff not performing proper hand hygiene before flushing R132's urinary catheter. This deficient practice has the potential to affect all the resident with urinary catheter.</p> <p>Findings Include:</p> <p>Cross-reference to F880 Infection Prevention & Control</p> <p>On 10/22/24 at 11:30 AM R132 was observed sitting in his wheelchair near his bed with his urinary catheter tubing on the ground. Interview was conducted with the Certified Nurse Assistant (CNA) 1 who was working with R132. Inquired if the tubing should be on the ground and she confirmed it is not supposed to be left on the ground and she put on gloves and lifted the tubing off the ground and moved it to the side of R132's wheelchair.</p> <p>On 10/23/24 at 10:01 AM observed R132 sitting in his wheelchair outside of his room and Registered Nurse (RN) 5 was talking with resident. Interview was conducted with RN5 at this time. Inquired about the blood that was observed in the urinary catheter tubing of R132 and RN5 stated she was going to flush the urinary catheter. R132 was transferred into his bed by RN5 and maintenance staff (who is a CNA). RN5 continued using the same gloves as she flushed R132's urinary catheter. Afterwards RN5 was interviewed and asked if she should have taken off the dirty gloves, performed hand hygiene and then put on clean gloves before flushing R132's catheter, and she confirmed that she should have done that.</p> <p>On 10/23/24 a RR was done of R132's Electronic Health Record (EHR) which revealed he is an [AGE] year old male who was admitted to the facility on [DATE] and his diagnoses include, but are not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side; Type 2 diabetes mellitus; personal history of malignant neoplasm of prostate; chronic kidney disease, stage 3a; and urinary tract infection, site not specified. Continued RR found there was no physician's order for R132 to have his urinary catheter flushed by licensed staff.</p> <p>On 10/24/24 at 03:00 PM interviewed RN6 inquired if nurses are required to have a doctor's order to perform a urinary catheter flush and she confirmed this.</p> <p>On 10/24/24 at 03:05 PM interviewed RN5 and inquired if she had a doctor's order to flush R132's urinary catheter tubing prior to doing this on 10/23/24. RN5 reviewed R132's doctor's orders. RN5 stated she did not find an order to flush R132's urinary catheter tubing. Inquired if nurses need to have the order to be able to do this and RN5 confirmed she needed a doctor's order. RN5 stated she would contact the doctor.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RR on 10/25/24 of R132's EHR revealed a doctor's verbal order with a created date of 10/24/25 at 04:12 PM which stated May flush urinary catheter when urine output is bloody or urine output is decreased. Every shift - PRN PRN 1, PRN 2, PRN 3</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on interviews and record review, the facility failed to ensure controlled medication was reconciled for one of four medication carts sampled. Review of the Controlled Medication Reconciliation Log (CMR Log) documented on 10/02/24, nursing staff did not sign the log with the on-coming evening shift nurse indicating all controlled medications for medication cart was reconciled at change of shift and on 10/24/24 and 10/25/24, nursing staff pre-signed the CMR Log prior to reconciling and verifying the controlled medications count with the on-coming evening shift. As a result of this deficient practice, the facility is at potential risk for diversion of controlled medications.</p> <p>Findings Include:</p> <p>On 10/24/24 at 08:40 AM, conducted an inspection of medication cart # 4 with Nursing Staff (NS)3. Review of the CMR Log documented NS3 had already signed the box which indicated the controlled medication count was completed with the on-coming evening shift nurse which attested the count was accurate, prior to doing the actual count. Inquired with NS3 regarding when the CMR Log should be signed and if NS3 had pre-signed the form. NS3 stated that she was going to work a double shift, so she would be signing for both the off-going and on-coming evening nursing staff and would sign as the off-going nurse with the staff working the night shift. NS3 explained, she would have the keys for medication cart #4 for the entire day and evening shift, then count the controlled medications with the on-coming night shift.</p> <p>On 10/25/24 at 09:40 AM, reviewed the unit schedule which documented NS3 had worked until 06:00 PM on 10/24/24 and not the entire 8 hour evening shift as reported by NS3.</p> <p>On 10/25/24 at 11:15 AM, reviewed the CMR Log on medication cart #4. The CMR Log documented NS3 did not provide an additional signature attesting that the controlled medication was reconciled with the on-coming nurse to ensure all controlled medications for medication cart #4 was correct and there were no missing controlled medication(s). Also, NS23 had pre-signed the CMP Log prior to counting the controlled medications with the on-coming evening nurse. Inquired if NS23 was working the evening shift and NS23 confirmed he/she was not working the evening shift and would be conducting a count of the controlled medication with the on-coming evening nurse at change of shift later in the day.</p> <p>On 10/25/24 at 11:40 AM, conducted a concurrent interview and record review of medication cart #4's CMR Log with Resident Care Manager (RCM)8. Informed RCM8 of this surveyor's conversation and documentation on the CMR Log for 10/24/24 and 10/25/24 which showed both day shift nurses pre-signing the CMR Logs prior to counting the controlled medications with another licensed nursing staff. Inquired with RCM8 regarding the facility's practice for counting controlled medications between shifts and what is expected of the staff conducting the counts. RCM8 stated the CMR Log should be signed in the presence of the other licensed nurse during change of shift, when handing over the keys to the on-coming licensed nursing staff, after confirming the controlled medication count was accurate. RCM8 confirmed NS3 should have signed the CMR Log again and in the presence of the on-coming nurse after both staff confirmed the accuracy of the controlled medication count and NS23 should not have pre-signed the CMR Log. Reviewed the missing signature on the CMR Log for the day shift nurse on 10/02/24. RCM8 confirmed licensed staff should have signed the CMR Log in the presence of the on-coming licensed staff but did not.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Medication Storage, Controlled Medication Storage policy and procedure documented, 6. At each shift change or when the keys are surrendered, a physical inventory of all controlled substances, . is conducted by two licensed or approved individuals per state regulation and is documented on the controlled substances accountability record ore verification of controlled substances count report.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observations, interview, and facility policy review, the facility failed to ensure drugs and biologicals are stored in a locked compartment. Proper storage of medications is necessary to promote safe administration practices and to decrease the risk for diversion of residents' medications. This deficient practice has the potential to affect all the residents in one of the four units in the facility.</p> <p>Findings Include:</p> <p>Concurrent observation and interview were conducted on 10/22/24 at 11:00 AM. One of the facility's medication carts was observed unlocked and unattended. The cart was assigned to Licensed Practical Nurse (LPN) 10, who was observed in one of the resident's rooms. Once LPN 10 exited the resident's room, she was asked about the unlocked and unattended medication cart. LPN10 confirmed that the medication cart should not have been left unlocked and unattended.</p> <p>Concurrent observation and interview were conducted on 10/23/24 at 03:17 PM. One of the facility's medication carts was observed unlocked and unattended. The cart was assigned to Registered Nurse (RN) 11. Once RN11 came back to the nurse's station, she was questioned about the unlocked and unattended medication cart. RN11 confirmed that the medication cart should not have been left unlocked and unattended.</p> <p>A review of the facility policy titled, Storage of Medication, dated 01/24 was conducted on 10/23/24. The policy noted, 3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets, and medication supplies should remain locked when not in use or attended to by persons with authorized access.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, Record Review (RR) of Resident's Electronic Health Record (EHR) and interview, the facility failed to assure one of the sampled resident's (Resident (R) 132) urinary catheter tubing did not rest on the ground, failed to have staff remove dirty gloves, perform hand hygiene and put on clean gloves before flushing R132's urinary catheter, and perform hand hygiene after disposing of dirty gloves before putting on clean gloves during a dressing change for R58. The deficient practice puts the residents at risk for facility acquired infections.</p> <p>Findings Include:</p> <p>1) On 10/22/24 at 11:30 AM R132 was observed returning to his room in his wheelchair with staff pushing his wheelchair. R132 was observed in his wheelchair near his bed and his urinary catheter tubing was observed resting on the ground. Inquired with Certified Nurse Assistant(CNA) 1, if the tubing should be on the ground and she stated it should not be on the ground. CNA1 put on gloves and moved the tubing so that it was not resting on the ground.</p> <p>On 10/23/24 at 10:01 AM observed R132 sitting in his wheelchair outside of his room. An interview was conducted at this time with Registered Nurse (RN) 5. Inquired with RN 5 about blood that was observed in R132's urinary catheter tubing. RN5 stated she was going to flush it. Observed RN5 push R132 in his wheelchair from the hallway to his bedside. RN5 and Maintenance Staff (MS) 1 (who is also a CNA) transferred R132 from his wheelchair to his bed. During the transfer RN5 was wearing gloves. After transfer RN5 did not dispose of dirty gloves and perform hand hygiene. RN5 proceeded to flush R132's urinary catheter which had blood and urine in the tubing. Resident tolerated it well. Afterwards RN5 changed her gloves, threw away dirty gloves and put on clean gloves and did not perform hand hygiene. RN5 placed a holder (STAT LOCK) on resident's right leg which she stabilized R132's urinary catheter tubing in. Inquired of RN5 if she should have disposed of dirty gloves and perform hand hygiene prior to flushing R132's urinary catheter and RN5 confirmed she had not done hand hygiene and did not change her gloves prior to flushing R132's urinary catheter which she acknowledged she should have done.</p> <p>2) On 10/24/24 at 10:11 AM observed suprapubic catheter dressing change for R58 done by RN5. R58 was laying in his bed, no distress, was cooperative with dressing change, reported to nurse that he does not have any pain. Site was clean, no drainage and no inflammation. RN5 disposed of old dressing and washed her hands. RN5 donned clean gloves and cleaned site with saline. RN5 took off her gloves and threw them away, no hand hygiene was performed before putting on clean gloves. Ointment was applied to the site with a sterile q-tip and dressing gauze was applied with paper tape.</p> <p>On 10/24/24 at 08:45 AM requested Hand Hygiene policy from Administrator which she provided that day.</p> <p>Review of facility policy titled Handwashing and Hand Hygiene Policy with a revision date of 05/23/23 states Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: . c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice). t. Before donning and after doffing gloves and PPE.</p>		