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	07/15/2021

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interviews and document review the facility failed to provide translation services to one resident (R)1 in her primary language when investigating an allegation of abuse. On 06/02/21, a Certified Nursing Assistant (CNA)1 reported to the facility that CNA2 slapped R1 when providing care the previous week. R1 had limited English proficiency and her primary language was Korean. When R1 was interviewed and assessed after the allegation, the facility did not provide or offer appropriate translation services to ensure R1 was able to communicate and fully understand. As a result of this deficiency, there was the potential the facility did not obtain critical information during the investigation to determine if the allegation was substantiated or not. This could affect any resident whose primary language is not English and put residents in an unsafe environment. Findings include: 1) The facility has a large population of resident's whose primary language is not English. The Charge Nurse (CN)1 provided documentation that 23 of the 47 residents on the second floor where R1 resided did not identify English as their primary language. Primary language of residents included; Cantonese/Mandarin, Chuukese, Korean, Vietnamese, Laotian, and Visayan (a Phillipine language). 2) R1 is an [AGE] year old admitted to the facility on [DATE]. She had a stroke in 2018 that affected her left side and has dysphagia (difficulty swallowing) and currently has a gastric feeding tube (G-tube, a tube inserted through a small incision in the abdomen into the stomach and is used for long-term enteral nutrition). R1's care plan (CP) dated 07/05/21 indicated R1's primary language is Korean. A CP goal was; R1 will be able to express/communicate needs/wants effectively with staff. One of the approach's was to provide interpretive services. The CP also included; 3) On 07/14/21 at 12:26 PM during an interview with Family Member (FM)1, FM1 said R1's primary language is Korean and that she understands simple basic English, but doesn't use words. The FM1 went on to say R1 understands and, Can finish a sentence four to eight words but struggles to expand her thoughts into words. 4) On 07/14/21 at 09:30 AM during an interview with the Social Services Director (SSD), she said her responsibility in an alleged abuse is to interview the alleged victim (AV) and other residents. The SSD said they could use an interpreter service if the residents primary language was not English, but that sometimes the families want to interpret. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD said she did not use an interpreter when she met with R1 regarding the alleged incident but did not recall why. The SSD said she communicated with R1 non verbally. When asked to demonstrate her communication with R1, the SSD used the thumbs up gesture asking are you OK?, and pointed to areas and said sore? 5) On 07/14/21 at 10:05 AM during an interview with the Director of Nursing (DON), he said he assessed and interviewed R1 with a CNA right after hearing of the allegation. The DON said R1 knew the name of the CNA with him, and that R1 can speak one or two words. The DON said when he interviewed R1 he used hand gestures. When asked who they utilize to interpret, the DON said they try to use family if we can and that they had a translation service that was not working well. He went on to say the Administrator (ADM) is trying to secure a good translation service. The DON said he did not utilize R1's FM's to assist with translation because of the COVID visitor policy. 6) On 07/15/21 at 08:22 AM, during an interview with the second floor Charge Nurse (CN), she said when they need an interpreter, they usually arrange a week in advance and utilize mostly for doctors appointments. The CN said we use the family and google translate. 7) R1's Minimum Data Set (MDS) assessment dated [DATE] documented R1 Sometimes understands-responds adequately to simple, direct communication only and is Sometimes understood-ability is limited to making concrete requests. The Observation Detail List Report dated 06/09/21 documented R1 had clear speech, and that she was alert and oriented to self and situation. 8) On 07/15/21 review of the facility policy titled Patient Rights dated 03/21/21. The policy included; 2. Planning and implementing care. The resident had the right to be informed of, and participate in, his or her treatment including; a. The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. 9) On 07/14/21 inquired if the facility had a policy for translation services. On 07/15/21 at 10:10 AM, the ADM provided a policy titled, Communicating with Persons with Limited English Proficiency (LEP) implementation date 07/15/21. the policy statement included; The purpose of this policy is to ensure meaningful communication with LEP residents and their authorized representatives involving their medical conditions and treatment. 10) On 07/14/21 at 01:11 PM, Surveyor (S)2 had a conversation with R1 in Korean. R1 was able to understand her and able to complete short sentences. On 07/15/21 at 01:36 PM, S2 utilized translation service (TS)1 to speak with R1 in Korean. At that time, R1 did not respond when asked if someone hit her in the face, but said she was scared of someone who works at the facility. R1 said someone had pulled her hair when she told the staff member the water was too cold while her hair was being washed.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39853 Based on interviews, and record review (RR), the facility failed to develop and implement adequate policies and procedures for investigation and response to an allegation of abuse. Although the facility had a policy in place, it lacked guidance/procedures to assist the leadership team in the response and investigation of an allegation of abuse. As a result of these deficiencies, there is the potential the facility's reporting, response and investigation to allegations of abuse and neglect are inadequate to keep residents safe. Findings include: 1) On 06/02/21, Certified Nursing Assistant (CNA)1 reported to the Administrator (ADM), Director of Nursing (DON), and Human Resources Director (HRD) he witnessed his preceptor, CNA2 slap Resident (R)1's hand and then R1's face as R1 was pinching CNA2 during morning care on or about 05/27/21. 2) On 07/23/21 reviewed the facility policy titled Abuse, Neglect and Exploitation dated 03/01/21. The policy included the following statements: Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: . b. establish policies and procedures to investigate any such allegations . 2. The facility will designate Abuse Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect . to the State Agency . V. Investigation of Alleged Abuse, Neglect and Exploitation .B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 4. Providing complete and thorough documentation of the investigation; . 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witness, and others who might have knowledge of the allegations; VII. Reporting/Response A. The facility will have written procedures that include: . 2. Assuring that reporters are free from retaliation or reprisal; 3) The staff interviewed during the investigation was limited to the staff on duty when the incident was reported (06/02/21) and did not include other staff on the day of the alleged incident (05/27/21). In addition, the AV is not proficient in English and was not interviewed in her primary language of Korean. 4) Review of R1's medical record and investigative notes revealed lack of documentation in the following areas: No documentation in the medical record R1's physician (MD)1 was notified. The Charge Nurse was able to locate a handwritten note on a shift report that the MD1 was notified when he came to the facility the next morning (06/03/21), but agreed it should have been documented in the medical record. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MD1's note of R1's exam on 06/03/21 did not mention notification of the abuse allegation, and did not include any notation of physical exam related to it. During a phone interview with MD1 on 07/15/21 at 09:00 AM, he said he did not recall the incident and said normally he would write something in his notes. R1's family came to the facility for a meeting to discuss the allegation with the DON on 06/22/21. Later that day the Family Member (FM)2 contacted the DON for further discussion. There is no documentation of the meeting or phone call. On 07/14/21 at 09:30 AM during an interview with the Social Worker Director (SSD), she said her responsibility in an allegation of abuse is to interview the alleged victim (AV) and other residents. When asked if there had been any follow up with the R1 after the initial interview, the SSD said, there is no real policy, but I checked in with staff and the residents. I would check in informally and speak with them. The SSD said she checked on R1 a couple times after the alleged incident, but did not document the visits. On 07/14/21 at 10:40 AM reviewed R1's records with the DON. The DON said R1 is a long term care resident, and the requirement for documentation by nursing staff is once a week unless something is out of the ordinary (i.e. MD visit) which would be documented. He went on to say in a situation of alleged abuse, the resident should be assessed for any changes and documented every day for three days. The DON validated there was no documentation of these assessments. 5) Cross Reference Ftag 609 Reporting of alleged abuse An allegation of potential abuse was brought to the attention of the ADM and DON on 06/02/21. The SA did not receive an initial report of the allegation or a report of investigation findings. 6) Cross Reference Ftag 608 Reporting of Reasonable Suspicion of a Crime. The facility did not have written policies how to assure the reporter was free from retaliation or reprisal.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 39853 Based on interviews and document review the facility failed to report an alleged violation of abuse to the State Agency (SA) as required. An allegation of potential abuse was brought to the attention of the Administrator (ADM) and Director of Nursing (DON) on 06/02/21. The SA did not receive an initial report of the allegation or the investigation findings Findings include: On 06/02/21, Certified Nursing Assistant (CNA) 1 reported to the Administrator (ADM), Director of Nursing (DON), and Human Resources Director (HRD) that he witnessed his preceptor, CNA2 slap R1's hand and then R1's face as R1 was pinching CNA2 during morning care on or about 05/27/21. On 07/14/21, reviewed the facility policy titled Abuse, Neglect and Exploitation dated 03/01/21. The policy states; The facility would designate an Abuse Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. The policy also stated; Reporting of all alleged violations to the Administrator, state agency, adult protective services and all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. In addition, the policy included, The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results when final within 5 working days of the incident, as required by state agencies. On 07/14/21 at 09:30 AM during an interview with the Social Service Director (SSD) when asked who the Abuse Coordinator was, she replied, My understanding is it would be the Administrator. The SSD said it was the Director of Nursing that reports the incident to the SA, and she reports it to Adult Protective Services when directed to do so by the ADM and DON. On 07/14/21 at 10:05 AM during an interview with the DON he said he had not reported it to the State Agency.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. 39853 Based on interviews, record review (RR) and observation, the facility lacked evidence that the allegation of abuse brought to their attention on 06/02/21 was thoroughly investigated. The Resident (R)1 was not interviewed in her primary language and there was no documentation R1 was monitored for behavioral changes post alleged incident. In addition, there was conflicting information obtained from interviews from R1's family members (FM's) and the Director of Nursing (DON) regarding notification of the alleged incident and a conversation FM2 had with the DON on 06/22/21. The investigation response document provided by the DON included inaccurate information. As a result of this deficiency, there was potential the facility did not have critical information during the investigation to determine if the allegation was substantiated or not. If a thorough investigation is not conducted, there is potential all residents could be in an unsafe environment. Findings include: 1) On 06/02/21, Certified Nursing Assistant (CNA) 1 reported to the Administrator (ADM), Director of Nursing (DON), and Human Resources Director (HRD) that he witnessed his preceptor, CNA2 slap R1's hand and then R1's face as R1 was pinching CNA2 during morning care on or about 05/27/21. CNA2 was the preceptor for CNA1 who was a new hire and started his orientation on 05/26/21. 2) Time frame from interviews and documents (Adult Protective Services [APS], Facility investigation notes and staff questionnaires): 05/27/21 Facility determined date alleged abuse may have occurred 06/02/21 Approximately 10:30 AM, CNA1 reported the allegation of abuse reported to the DON. Investigation conducted by leadership team. 06/02/21 03:00 PM facility reported to APS. Report did not include information on alleged perpetrator (AP) or witness. 06/02/21 05:11 PM: facility left message left on APS after hours voice mail box the DON had determined that the allegations were unsubstantiated and to contact DON for additional information. 06/03/21 Both CNA1 and CNA2 returned to work. CNA2 assigned to second floor where R1 resides and CNA1 reassigned to first floor. CNA1 requested to go home after meeting with DON and receiving disciplinary action for failure to report the incident immediately. 06/20/21 R1's FM 1 contacted by attorney generals office inquiring about the allegation. 06/22/21 R1's FM1 and FM2 presented to the facility unannounced for meeting regarding allegation. Later that day FM2 contacted the DON to discuss additional concerns related to the allegation. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3) On 07/14/21 at 10:05 AM during an interview with the DON, he said he interviewed staff that worked that day of the alleged abuse, but also wanted to get information from other staff who CNA2 oriented and worked with her. On 06/02/21, the DON documented in the investigation notes; 5 staff members were individually interviewed in accordance with Critical Element Pathway Guidelines, CMS form 20059 (5/2017). They also answered a standardized questionnaire about the alleged incident. On 07/14/21 reviewed the staff questionnaires. There were six questionnaires provided by the DON which were all dated 06/03/21. Five were completed by CNA's (CNA3, CNA4, CNA5, CNA6 and CNA7) and one by a Registered Nurse (RN)1. All staff that completed the questionnaire were working the day the incident was reported (06/02/21). Review of the staffing schedules revealed only two of the five CNA's (CNA3, CNA4) worked the day (05/27/21) the facility determined to be the date of the alleged incident. The other staff working 05/27/21 were not interviewed. When the DON was asked to clarify the date on the questionnaire, he said, I gave the staff the form late in the afternoon on the 2nd (06/02/21), but I dated them wrong (06/03/21) when I wrote everything up. 4) On 07/14/21 reviewed the document provided by the DON of the facility response and investigation of the allegation. On 06/03/21, the DON wrote; Of note, resident's daughter took resident to the hairdresser the next day May 28, 2021 by vehicle. The daughter and son are very active in their mother's well-being. Resident has always conversed with daughter and son about any concerns, changes, wants or needs in the past. There were no concerns verbalized by daughter upon returning her mother back to the facility. Resident appeared in her usual state of health, personality, and mentation. During an interview with the DON on 07/14/21, he said he felt if something had happened, R1 would have mentioned it to her daughter when she took her to the hairdresser. The DON later said he became aware that R1 did not go out to the hairdresser with her daughter. 5) During an interview with R1's daughter on 07/14/21 at 04:05 PM, stated the first time she saw R1 after the alleged abuse allegation was 06/01/21 and again on 06/15/21, when she took R1 to see the acupuncturist. R1 mentioned that someone was hitting her but I just let it go . She (R1) said it so matter of fact and wasn't angry. She (R1) repeated it a couple of times. At that time, the daughter was not aware of the allegation and did not find out until her brother called her on 06/20/21. On 06/22/21, me and my brother went down there [the facility] . unannounced and met with DON for the first time for a meeting. R1's daughter explained after the meeting she called the DON the same day and expressed her disappointment with facility not informing her brother or her of the allegation. R1's daughter then informed DON of what R1 said to her on 06/01/21 and 06/15/21. She said the DON responded with .why didn't you tell me earlier when in the office, you should have told me about it . 6) Interview with DON on 07/14/21 at 10:05 AM, he said he did not think he took notes during the family meeting on 06/22/21. The DON said , I should have called them (family) right away. That was my error. On 07/15/21 at 01:08 PM during a second interview with the DON, he confirmed R1's daughter called him after the meeting and wanted to talk about the blood on the mask. He said the daughter told him one time the acupuncturist changed R1's mask when she was at the appointment because there was blood on it. The DON said he followed up with the Charge Nurse (CN) and it was determined that the blood was probably due to R1's dry cracked lips. The DON said he had a hard time understanding her (daughter) and tried to ask her so I could understand. The DON said he did not hear the daughter say R1 told her on two separate occasions that someone was hitting her. 7) Cross reference Ftag 607 Develop/implement Abuse/neglect Policies. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to develop and implement adequate policies and procedures for investigation and response to an allegation of abuse. Although the facility had a policy in place, it lacked guidance/procedures to assist the leadership team in the response to an allegation of abuse. The facility did not have adequate documentation in the medical record regarding notifications to physician and family, or follow up with the R1. In addition, the facility took actions toward the reporter in a manner that did not promote reporting for fear of reprisal. 8) Cross reference Ftag 552 Right to be informed in a language that is understood. The facility failed to offer or provide translation services to R1 in her primary language when investigating the allegation of abuse. R1 had limited English Proficiency and primary language was Korean. The facility did not immediately contact the family who could have assisted with interpretation in an emergency. In addition, there was a CNA on duty at the time that spoke fluent Korean who knew R1. 43414 9) On 07/14/21 at 08:45 AM, spoke with R1 in her room in English, R1 initially nodded her head up and down in response with surveyor's introduction and questions and then began to respond with one word per question. Surveyor who also knows Korean asked R1 questions in Korean and R1 responded with one word per question. At 01:11 PM, surveyor went back to speak with R1 in Korean and R1 conversed in 3 to 4 word sentences. Surveyor inquired if R1 had been hit by someone who works at the facility and R1 stated no in Korean, then began changing the subject. Surveyor then inquired if she is enjoying her time at the facility, R1 stated she is having a hard time at the facility but did not further elaborate and changed the subject. On 07/15/21 at 01:40 PM, interviewed R1 utilizing the facility's recent contracted interpreter services over the phone, utilizing a Korean interpreter. Initially R1 responded to questions by nodding her head up and down, with occasional no responses. Surveyor inquired if a staff member had hit her and if a staff member hit her in the face, R1 did not respond to both questions. Surveyor then asked if a staff member hurt her, R1 responded and stated a staff member pulled her hair about 2 months ago. Further inquired about the incident and R1 stated the staff member was angry at her so she pulled her hair while taking a shower. R1 informed the staff member the water was too cold when the staff member pulled her hair. Surveyor inquired if R1 had let anyone know about the incident and R1 stated she informed a Korean supervisor who responded by asking R1 why she did not inform someone sooner. At the end of the interview R1 repeatedly stated she was scared.