STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125043	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEARL CITY NURSING HOME	**919 LEHUA AVENUE PEARL CITY, HI 96782**

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 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, and record reviews (RR), the facility failed to assess, prepare, and implement discharge planning for one resident (R)1 of three sampled residents selected for review. This deficient practice placed R1 at high risk for harm, financial exploitation, and/or death. Findings include: On [DATE] at 10:19 AM, interview with Administrator and Director of Nursing (DON), who stated R1 was discharged to her alleged sister (AS) on [DATE]. Administrator stated they attempted numerous times to contact R1's family member and documented responsible party for emergency, alleged daughter (AD) and alleged friend/caregiver (AFC) on day of discharge but they never responded. Administrator stated the facility found R1 to be very coherent and oriented to time, place, and person, in addition to the fact that R1 had no diagnoses of dementia or [MEDICAL CONDITION] on admission. Administrator and DON stated on day of discharge, facility was unable to reach both AD and AFC and R1 was anxious to leave had instructed the staff to call her AS and provided staff the phone number to call. Administrator said AS who R1 said was a sister turned out not to be a real sister (no blood relationship) but someone R1 had known for many years. Administrator said they did not know that at the time. Administrator stated adamantly that they also did not know R1 had a guardian. Administrator said neither AD nor AFC represented or reported themselves as guardian nor did they presented any paperwork showing they were R1's guardian. The facility never questioned R1's ability to make her own decisions. It was later when R1 was dropped back off at the facility by AS that they found out R1's guardian was AFC. On [DATE] at 12:35 PM, interview with R1 who was brought into the small conference room on the 5th floor by staff in a wheelchair. R1 was observed to be an elderly female, well groomed and wearing a face mask. R1 greeted surveyor with a warm smile and agreed to be interviewed privately. R1 was able to converse and answer questions appropriately. R1 was oriented to place, time (did not know the exact date), and persons. R1 stated on day of discharge, she and the facility were unable to reach AD and AFC by phone. R1 stated that is not unusual because she herself was never able to reach them before while at the facility. R1 stated AD is a bad person. R1 said AD has been telling everyone in Chinatown that she (R1) died . When queried, R1 admitted AD is not a real daughter of hers. R1 said many years ago, when AD was young, her father asked her to adopt AD but she did not want to. As for AFC who is court ordered as her guardian and conservator, R1 stated vehemently she does not know AFC and has never met her before. R1 stated AFC is AD's friend and not hers(R1). R1 said her husband passed away many years ago and they have a house by Lanakila behind the [MEDICAL CONDITION] (TB) testing center. R1 said it was sold for $600,000 plus. R1 denied signing any guardianship papers or going to court for her guardianship. R1 stated because they could not reach AD or AFC on day of discharge, she told staff to call AS and recited the phone number to staff to call. R1 admitted AS is not a real sister by blood. R1 said she knew AS as a friend for many years and they started calling each other sisters. R1 said AS has been informed previously by herself that she may be discharged from the facility soon and AS has agreed to pick her up when that happens. R1 said day of discharge [DATE], AS came with a male friend. R1 was queried about the male friend who reportedly was her son. R1 stated the male friend was not her son but a taxi driver. R1 said the taxi driver agreed to drive them to AS's house for $200. R1 said she was going to the bank with them to get the taxi driver $200 and $5,000 for AS to take care of her. R1 said she was unable to get them the money but was able to stay with AS for two days. R1 said AS got tired of caring for her and wanted her out. R1 stated she was dropped back off at the facility. R1 said she does not understand how AFC could become her guardian and conservator when she did not sign anything or even go to court for a guardianship. R1 stated she is very worried and upset about her money and the fact that AFC whom she doesn't know or never met before could be making decisions for her. [DATE] at 01:10 PM, interview with Registered Nurse (RN)1 who confirmed on day of discharge, they were unable to reach by phone R1's AD who was listed as responsible party/emergency contact to pick up R1. RN1 said she was working with the Social Worker (SW) on the discharge and thought the SW had made all the arrangements prior to discharge so when R1 said to call AS to pick her up, RN1 did not think anything was amiss. RN1 said when AS came to pick up R1, AS was given the discharge instructions and AS signed it. On [DATE] at 01:45 PM, RR showed physician's orders [REDACTED]. Discharge instructions from facility reflected medication list, diet (no added salt), and to follow-up with primary care physician (PCP) in one week after discharge. Discharge instructions were signed by AS on day of discharge. On [DATE] at 12:50 PM, interview with SW who confirmed on day of discharge, they were unable to reach AD and AFC by phone to pick up R1. SW stated AD and AFC did not respond to their calls. SW confirmed the facility did not do any discharge training or preparation with AS prior to R1's discharge because of Covid-19, visitors were restricted from the facility. SW stated AS was never listed as a caregiver for R1. On [DATE] at 02:05 PM, RR of documentation by SW in the Interdisciplinary Progress Notes dated [DATE] at 1020 showed SW spoke with the attorney who completed the guardianship for R1. SW informed this attorney the facility never received any guardianship papers from AFC. The attorney told the SW he will make sure the facility gets a copy of the guardianship paper as soon as possible. SW then documented, received from AD and AFC the guardianship papers and copies will be placed in R1's medical record. RR of R1's Comprehensive Care Plan and Interdisciplinary Progress Notes reflected no documentation of appropriate assessment, training (even by phone), and continuous discharge planning prior to R1's discharge with AS whom R1 was discharged to on [DATE].

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE