STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance on 06/30/22. The facility was found not to be in substantial compliance with §42 CFR 483 Subpart B. Seven Facility Reported Incidents (FRIs) from the Aspen Complaints/Incidents Tracking System (ACTS) were investigated, ACTS #9559, #9575, #8715, #8481, #8167, #8114, and #8478. ACTS #9575 was substantiated. Survey Dates: 06/27/22 to 06/30/22 Survey Census: 85 residents Sample Size: 18 residents	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 600		

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
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 1	F 600		

failed to protect one resident's right to be free from abuse from other residents. As a result of this deficient practice, Resident (R)22 was observed by staff hitting R23 in the left temple, without provocation. This deficient practice has the potential to affect all residents in the facility.

Findings include:

On 06/29/22 at 09:50 AM, conducted a record review (RR) of a facility-reported incident (ACTS #9575) documenting a resident-to-resident abuse allegation occurring on 06/09/22. Per the completed facility report received by the State Agency (SA) on 06/13/22, "At 0845 this morning, Resident [R23] ... was in his wheelchair ... [Resident 22] exited his bed, headed toward the bathroom ... suddenly turning toward [Resident 23] ... and striking him on his (L) [left] temple."

During a review of the facility's Resident to Resident Abuse Allegation Checklist, completed by Charge Nurse (CN)1 on 06/09/22, the following was noted: "Pt [patient] B [R22] got frustrated & hit Pt A [R23] because Pt A makes noise occasionally."

A review of the facility's Abuse: Patient/Resident Policy, last revised on 05/01/17, noted the following regarding physical abuse: "includes hitting, slapping, pinching, kicking ..."

On 06/30/22 at 07:26 AM, an interview was done with CN1 in the fourth-floor hallway. CN1 stated he was not the staff member who witnessed the incident, but he did initiate the investigation and completed the checklist referenced above. When asked about documenting that R22 hit R23 out of frustration, CN1 stated that is what the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2	F 600		

witness, Certified Nurse Aide (CNA)2 reported to him. CN1 continued on to explain that when he interviewed R22 following the incident, he nodded that he hit R23 but CN1 could not tell if R22 was just nodding his head to everything being said or actually confirming that he remembered doing that. When asked, R22 could not express to CN1 why he hit R23, "because of his aphasia [loss of ability to communicate in words]."

On 06/30/22 at 07:52 AM, an interview was done with CNA2 in the fourth-floor hallway. While recalling the incident, CNA2 stated he had just gotten R23 up to a wheelchair and placed it in the center of the room so he could adjust the footrests, R22 came around his privacy curtain with his walker, and began walking towards the bathroom. As he passed the wheelchair, R22 punched R23 straight on, hitting R23 on the left temple with the front of his closed fist. CNA2 stated that R22 did not appear startled when he came around his privacy curtain, and the punch did not look accidental. CNA2 described R22's movements as "purposeful" and deliberate. CNA2 stated that he thinks R22 might have been frustrated with R23 because of his history of yelling out, but CNA2 was not aware of any behaviors from either resident that morning or the previous night. CNA2 could not recall any verbalizations or expressions of frustration from R22, but "just think[s]" that could be the reason for the incident. When asked about R23's behaviors, CNA2 stated that "sometimes" R23 would call or yell out in the middle of the night for no reason.

On 06/30/22 at 10:30 AM, during a review of R22's progress notes, the following was noted in Medical Doctor (MD)1's MD Note from 06/09/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 3 at 03:00 PM: " ...he [R22] struck his roommate ...has difficulty giving information due to aphasia but tells me he was frustrated. Nursing reports the roommate frequently yells out, bothering others in the room. [R22] ... has been moved to another floor ... [and] tells me he is happy about that."	F 600		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview with staff members, the facility failed to assure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment for two (Residents 4 and 37) of 18 residents in the sample Findings include: 1) On 06/28/22 at 01:00 PM observed Resident (R)4 ambulating in the hall wearing long pants and a shirt with stand by assist. On the morning of 06/29/22 observed R4 ambulating in the hall dressed with long pants. Record review on 06/30/22 at 07:58 AM found a physician's order for "onsie suit/clothing to help with or control behavioral urges (i.e. exposes self to others). A review of the quarterly Minimum Data Set (MDS) with an assessment reference date of 03/18/22 notes in Section P. Restraints (physical restraints are any manual method or physical or mechanical equipment attached or	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 4	F 641		

adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) the use of the onsie (one-piece item of clothing, usually made of soft material like fleece or jersey cotton, which covers arms, legs, torso and sometimes feet) was not coded as a restraint. Review of quarterly MDS with assessment reference date of 01/26/22 also found physical restraints were not coded.

On 06/30/22 at 08:02 AM concurrent record review and interview was done with the Charge Nurse (CN)1. Inquired whether the facility assessed the use of the onsie as a restraint? CN1 replied that R4 wears the onsie when he is out of the room as when he has urges "he's pretty fast." Further queried whether the use of the onsie is included in the care plan. Review found for the problem of resident practicing sexual expressions in public areas or in front of others, the goal was to practice sexual expression in private only. An intervention included "When I leave my room please ensure I have my one-piece jumpsuit on." This was dated 12/29/21. CN1 also found a consent for use of medical device, jumpsuit/onsie signed by the resident's guardian. CN1 was asked again whether the onside is a physical restraint. CN1 deferred to the MDS Coordinator (MDSC)1.

On 06/30/22 at 08:29 AM interviewed the MDSC1. MDSC1 was asked whether the onsie is a restraint. MDSC1 reported R4 will ask to wear the onsie. MDSC responded that they did not code the onsie as a restraint as it does not impede the resident from moving around. A review of the MDS manual was done with MDSC1. The definition of a physical restraint

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 5	F 641		

was reviewed. MDSC confirmed R4 is unable to remove the onsie by himself as he requires more assistance for dressing. Further queried where is the fastener for the onsie, MDSC1 reported there is a zipper in the back. MDSC1 also confirmed wearing the onsie restricts R4's access to his body. Following review of the definition of a physical restraint, MDSC1 was agreeable the onsie looks like it is a physical restraint.

2) On 06/28/22 at 10:48 AM, a record review of R37's medical chart was conducted that documented Resident (R)37 was admitted to the facility on 10/22/20 with diagnosis that include a history of polio and paraplegia secondary to Polio, Bipolar, Dementia, Chronic Obstructive Pulmonary Disease (COPD), and Benign Prostatic Hyperplasia (BPH). Review of R37's annual MDS with an assessment reference date of 10/29/21, Section I. Active Diagnosis, under Psychiatric/Mood Disorder documented R37 was coded for I5800. Depression (other than bipolar) and I5900. Manic Depression (bipolar disease). Review of R37's quarterly MDS with an assessment reference date of 01/28/22 and 04/29/22 documented R37 was coded for I5950. Psychotic Disorder (other than Schizophrenia) in addition to depression (other than bipolar) and manic depression (bipolar disease).

On 06/29/22 at 11:12 AM, conducted a concurrent record review and interview with Medical Doctor (MD)1 regarding R37's diagnosis. MD1 clarified that R37's depressive presentation is due to the resident's bipolar diagnosis and R37 does not have a clinical diagnosis of depression. MD1 also confirmed R37 does not have a psychotic disorder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 6 On 06/30/22 at 11:01 AM, conducted concurrent record review and interview with the MDSC2. Inquired with MDSC2 about how she determines the resident's active diagnosis. MDSC2 stated that she determines the active diagnosis by reviewing the Medication Administration Record (MAR), the listed diagnosis for ordered medications, and the diagnosis list that is printed on the Physician Order form. Requested for MDSC2 to provide documentation that would support an active diagnosis of psychotic disorder for R37. MDSC2 reviewed personal notes and the resident's medical records, then confirmed R37 currently does not and did not have an active diagnosis of psychotic disorder during both quarterly assessments (01/28/22 and 04/29/22). MDSC2 stated she must have accidentally miscoded R37's active diagnosis.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 7	F 656		

provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, and record review, the facility failed to ensure a comprehensive person-centered care plan that includes measurable objectives and timeframe to meet the resident's medical, nursing, and psychosocial needs identified on the comprehensive assessment was developed for one of 18 residents sampled, Resident (R)62.

Findings include:

On 06/27/22 at 11:11 AM, observed R62 in the 3rd floor dining room, seated in a wheelchair with a bedside table in front of the resident, and a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 8	F 656		

catheter bag attached to the bottom of the wheelchair seat. The catheter tubing was observed to be coming out the bottom of R62's left pant leg on the ground. Approximately 9-12 inches of tubing was in direct contact with the ground before the tubing was threaded through metal center bars (located under the wheelchair seat) elevated the catheter tubing off the ground. The catheter tubing that was on the floor also ran under a base leg of the bedside table (between two wheels).

On 06/27/22 at 12:30 PM, an interview was conducted with the 3rd floor Nurse Manager (NM)3 regarding observation of R62's catheter tubing in direct contact with the ground. NM3 confirmed the tubing should not be in contact with the ground.

A record review on 06/28/22 at 11:18 AM of R62's medical chart documented the resident was admitted on 05/13/22 with diagnosis that included chronic urinary retention and an indwelling Foley catheter. A review of R62's comprehensive care plan documented the facility did not develop a care plan for the resident's goals related to the indwelling catheter with measurable objectives, timeframe, and interventions to meet the resident's medical, nursing, and psychosocial needs. R62's admission Minimum Data Set (MDS) with an assessment reference date of 05/20/22 documented an indwelling catheter in Section H- Bowel and Bladder and Section V- Care Area Assessment, urinary incontinence and indwelling catheter care area was triggered and addressed in the care plan.

During an interview and concurrent record review of R62's medical chart on 06/29/22 at 01:30 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 9 NM3 confirmed that R62 was admitted to the facility with an indwelling catheter and a comprehensive care plan had not been developed for the use of the indwelling catheter. NM3 could not provide documentation of the involvement of the resident/ resident representative in the discussion of the risk and benefits of the use of the catheter, a plan for the removal of the catheter when criteria or indication for use is no longer present, assessments related to the indication for the use of an indwelling catheter, as well as criteria for the discontinuance of the catheter when the indication for use is no longer present, ongoing care and catheter removal protocols, or ongoing monitoring for changes in condition related to Catheter Acquired Urinary Tract Infections (CAUTI). On 06/30/22 at 11:17 AM, Registered Nurse (RN)3 reported that R62's catheter was removed, and a plan had been implemented for bladder training.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview with staff members, the facility did not provide necessary services for a resident who is unable to carry out activities of daily living to maintain good grooming. Findings include:	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 10	F 677		

On 06/27/22 observed Resident (R)12 in bed with Certified Nurse Aide (CNA)4 at bedside. CNA was planning to assist R12 with lunch and was raising the head of the resident's bed. Suddenly R12, tossed off her blanket and said "shit" and stated that she wanted to go home. R12 swore a couple more times and repeated that she wanted to go home. R12 sat up on the side of her bed and looked down at her feet and stated something is wrong with her feet. Observed, R12's toe nails were white, thick, and long. CNA4 attempted to assist R12 to put on her house slippers, she refused, and again said something is wrong with her feet. R12's feet looked swollen.

Record review on 06/29/22 at 11:16 AM found a physician order for triamcinolone cream for left foot rash/intertrigo (inflammatory rash of the superficial skin that occurs within a person's body folds) for fourteen days. The order was dated 05/04/22. The order was continued on 05/17/22. A review of the comprehensive/annual Minimum Data Set with assessment reference date of 03/25/22 notes R12 requires extensive assistance with one-person physical assist for personal hygiene (how resident maintains personal hygiene, including combing hair brushing teeth shaving, applying makeup, washing/drying face and hands).

On 06/29/22 at 12:45 PM, R12 was observed wheeling herself on the unit. At 01:11 PM she approached the nurses' station and was removing her house slippers and sock. Observed R12's left foot to be reddened and there was an indention on her ankle from her socks. Also observed an indention of her across the top of her foot below the ankle. The resident's toe nails were white,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 11 thick, and long. R12 stated something is wrong with her feet. The Director of Nursing (DON) and Charge Nurse (CN)1 was asked to look at R12's feet. CN1 stated R12's physician will be called to look at her feet. Inquired when was the last time R12's toe nails were cut. CN1 reported the podiatrist cuts R12's toe nails. The staff member seated at the nurses' station reported the podiatrist comes every three months. Staff members were asked when was the last time R12's nails were cut. Requested to review the podiatrist report. CN1 reviewed R12's medical chart and found the last podiatry consult was 11/19/21, the podiatrist debrided R12's nails.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and record review, the facility failed to provide adequate supervision while a resident wandered on the unit. Resident (R)12 was observed wandering on the unit and entered another residents' room. This has the potential to be unsafe as it may lead to an altercation. Findings include: R12 was admitted to the facility on 03/25/20 from	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12	F 689		

an acute hospital. Diagnoses includes but not limited to right intertrochanteric hip fracture, dementia, osteoporosis, hypertension, and depression.

On the afternoon of 06/27/22, R12 was observed seated in her wheelchair and wheeling herself on the unit. Initially the Minimum Data Set Coordinator (MDSC)2 walked alongside R12 and engaged her in conversation. MDSC2 left R12 and she was observed wheeling alone on the unit. R12 was observed to wheel into room 417 where R33 and R47 resides. The male resident in the bed closest to the door was not in the room. The curtains were drawn closed around the bed furthest from the door. A male resident was observed seated in a chair behind the curtain. There was a banner that was hanging from one side of the door. R12 continued to wheel herself about the unit.

Record review was done on 06/29/22 at 11:16 AM. Review of the "Elopement Risk Assessment" completed on 06/23/22 notes R12 yielded a score of 15 indicating high risk for elopement. Previous assessments done on 02/19/22, 12/22/21, 09/21, 06/30/21, and 03/16/21 found R12 yielded a score of 15 (high risk) for elopement. The "Fall Risk Assessment" completed on 02/24/21 indicates R12 is at risk for falls.

On 06/29/22 at 12:45 PM, R12 was observed wheeling herself on the unit. R12 would wheel out to the lanai where male resident, R67 was seated outside eating his lunch. R12 did not enter room 417. A wheelchair was parked to the left of the door and observed, the male resident closest to the door was seated in his lounger. R12 continued to wheel herself on the unit. Last

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 observation of resident wandering on the unit was 01:11 PM (26 minutes later). Review of the annual MDS with an assessment reference date of 03/25/22 assesses R12 cognitive abilities at 0 (zero) indicative of severe impairment. R12 was coded for wandering behavior (behavior of this type occurred daily). R12 also coded for not being at significant risk of getting to a potentially dangerous place or significantly intrude on the privacy or activities of others. Review of R12's care plan for being at risk form elopement noted the following interventions: redirect me as needed if I'm verbally or physically inappropriate towards staff of other residents, I understand that I may be given medications to calm me down if necessary; Involve interdisciplinary team, my family, physician in regard to my safety and/or others; check exit doors on my unit that the alarms are on; I like to self-propel my wheelchair around the unit, check on me every 1-2 hours prn and/or every turns regarding my whereabouts; use theatre rope by elevator as needed so that I don't get lost going in the elevator myself; stop sign at the theatre rope area (elevator) to help me remember I should not be by elevator area for safety; I have wanderguard system attached to my wheelchair, check that the system is functioning properly; and join my journey when I'm verbally saying that I want to go home, let me know that I am in the hospital because my doctor is caring for me and I hurt my hip, let me know that my family is/are aware that I am safe, this sometimes gives me peace of mind.	F 689		
F 700 SS=D	Bedrails	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 14 CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a resident was assessed for risk of entrapment from bed rails, review of the risk and benefits of bed rails with the resident representative, and obtain an informed consent for the use of bed rails for one resident (Resident (R)24) sampled. Findings include: On 06/27/22 at 02:24 PM and 06/28/22 at 09:35 AM, observed R24 resting in bed. During both observations, the right side of R24's bed was	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 15	F 700		

placed against the wall with the top left bedrail up. Certified Nurse Aide (CNA)4 was sitting near R24's bed and was asked about the resident's bed being up against the wall and the use of the bed rails. CNA4 stated that there was an order for the bed to be placed against the wall and the bedrail is up because R24 is impulsive, and it prevents the resident from falling out of the bed.

During an interview with R24's resident representative (Family Member (FM)1) on 06/28/22 at 09:40 AM, FM1 stated that consent was given for the facility to use a bed alarm and for R24's bed to be up against the wall. Inquired if FM1 gave consent for the use of bedrails and if the facility informed FM1 of the risk versus benefits for the use of bedrails. FM1 confirmed she did not give consent for the use of bedrails, was not informed of the risk of using bedrails, and was unaware that bedrails were being used.

Record review of R24's medical chart on 06/29/22 at 08:14 AM documented R24 was admitted to the facility on 07/17/19 with diagnoses that include Dementia with behaviors, Schizophrenia, Meniere's disease, hypertension, and a stroke that resulted in difficulty speaking. Review of R24's assessments documented a Medical Device Consent form for R24's bed to be up against the right side of the wall (dated 04/22/22) but did not document a Medical Device Consent form or an assessment for the safe use of bedrails. Review of the Physician Order form did not document an order for the use of bedrails. Review of the comprehensive care plan did not include documentation for the use of bedrails.

On 06/30/22 at 09:23 AM, conducted concurrent record review and interview with Charge Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 16 (CN)1. CN1 confirmed R24 does not have an order for the use of bed rails, an assessment was not completed, FM1 did not provide consent for the use of bedrails, and staff should not be using the bedrail for R24.	F 700		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure infection control practices were implemented for a resident (Resident (R)62) with an indwelling catheter.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 18 Findings include: On 06/27/22 at 11:11 AM, observed R62 in the 3rd floor dining room, seated in a wheelchair with a bedside table in front of the resident, and a catheter bag attached to the bottom of the wheelchair seat. The catheter tubing was observed to be coming out the bottom of R62's left pant leg on the ground. Approximately 9-12 inches of tubing was on the ground before the tubing was threaded through metal center bars (located under the wheelchair seat) and off the ground, then connected to the catheter bag (located at the back bottom of the wheelchair seat). The portion of the catheter tubing that was on the floor, went under one of the base legs of the bedside table (that was in front of the resident). The way the leg of the bedside table was positioned, it appeared that staff had ran over the catheter tubing with the wheels of the bedside table. On 06/27/22 at 12:30 PM, an interview was conducted with the 3rd floor Nurse Manager (NM)3 regarding observation of R62's catheter tubing in direct contact with the ground. NM3 confirmed the tubing should not be in contact with the ground. On 06/30/22 at 12:20 PM, conducted an interview with the Infection Preventionist (IP). The IP was informed of the observation of R62's catheter tubing being on the ground. IP confirmed the catheter tubing should not have been on the ground and should be kept off of the ground to prevent the potential for an infection.	F 880		
F 886 SS=E	COVID-19 Testing-Residents & Staff	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 19 CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 20	F 886		

(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure staff conducting point-of-care (POC) COVID-19 outbreak testing on themselves conducted the testing in a manner consistent with current standards of practice for conducting COVID-19 tests. As a result of this deficient practice, the facility placed the residents and staff at an increased risk of COVID transmission. This deficient practice has the potential to affect all residents in the facility, as well as all healthcare personnel, and visitors at the facility.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 21	F 886		

On 06/27/22 at 10:07 AM, observed four staff members outside the main entrance taking turns at two testing stations, swabbing themselves for COVID-19. There were no gloves or personal protective equipment (PPE) worn by any of the four staff members while testing and/or handling the test kits. There was no cleansing or wiping down of the testing stations observed between uses, nor were there any cleaning supplies available at the testing stations.

On 06/30/22 at 09:07 AM, an interview was done with the Infection Preventionist (IP) at the second-floor Nurses' Station. The IP confirmed that the facility was conducting outbreak testing twice a week of all staff due to COVID-positive staff members. The IP stated that all staff were sent the information/education on self-testing for COVID-19 by Staff Development. To his knowledge, there were no competency checklists, no audits, and no formal training done. As the IP, he does not expect to see staff wearing any PPE to conduct the tests or swab themselves, but he would like to see the testing stations wiped down between uses.

On 06/30/22 at 09:50 AM, an interview was done with Staff Development (SD)1. SD1 confirmed that the COVID-19 self-testing education had been sent out by e-mail to all staff on 07/28/21 and that there had been no formal education, competency checks, or audits done.

On 06/30/22 at 10:41 AM, during a review of the educational handout sent out by Staff Development, How to Collect an Anterior Nasal Swab Specimen for COVID-19 Testing, dated 04/13/21, the following was noted:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 22 "1. Disinfect the surface where you will open the collection kit."	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification survey was conducted by the Office of Healthcare Assurance (OHCA) on 06/30/22. The facility was found to be in substantial compliance with Appendix Z, Emergency Preparedness, §42 CFR 483.73 for long term care facilities.	E 000		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	**100 KEOKEA PLACE** **KULA, HI 96790**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345 SS=B	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: K-345 Fire Alarm System-Testing and Maintenance This STANDARD is not met as evidenced by: Based on record review with facility manager, the facility failed to provide documentation for smoke detector sensitivity testing, in accordance with, NFPA 72 National Fire Alarm and Signaling Code, 2010 edition, section 14.4.5.3. This deficiency could affect all residents, staff, and visitors during the insipient stage of a fire due to delayed or no response from smoke detectors within the facility. Findings include: During record review on 7/26/22 at approximately 11:15 am revealed that the facility failed to provide documentation for the smoke sensitivity testing of smoke detectors. The facility manager contacted the vendor and verified that the smoke detector sensitivity testing was not part of the maintenance contract and was subsequently added on for the next scheduled inspection. These findings were verified at the exit conference with the facility manager and Administrator on 7/26/22 at 12:15 pm.	K 345		

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

Electronically Signed

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125003	A. BUILDING _____ B. WING _____	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments THIS FACILITY MET THE LIFE SAFETY REQUIREMENTS OF APPENDIX "Z"; IN ACCORDANCE WITH CFR 483.73, REQUIREMENT FOR LONG-TERM CARE (LTC) FACILITIES	E 000		

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

Electronically Signed

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.