STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G001	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE , KULA, Hawaii, 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
E0000	Initial Comments The facility was found to be in substantial compliance with 42 CFR 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities, Emergency Preparedness, Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types, of the State Operations Manual, during the recertification survey conducted by the Office of Health Care Assurance (OHCA) from 07/05/23 - 07/07/23.	E0000		
W0000	INITIAL COMMENTS A focused fundamental recertification survey was conducted by the Office of Health Care Assurance on 07/05/23 - 07/07/23. The facility was found not to be in substantial compliance with the requirement(s) at 42 CFR §483, Subpart I. Survey Dates: 07/05/23 - 07/07/23 Survey Census: 8 Clients Sample Size: 4 Clients Supplemental Clients: 1 Client	W0000		
W0249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is NOT MET as evidenced by: Based on observations and record review, the facility	W0249		

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 reverse for further 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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W0249	Continued from page 1 did not assure 1 of 4 clients (Client 3) in the active case sample received a continuous active treatment program. Findings include: On 07/05/23 from 03:15 through 05:20 PM, Client (C)3's active treatment program was not implemented by staff members. Observations included: -At 01:25 PM, C3 was observed lying in bed with music playing. -At 03:15 PM, C3 was observed in her room, seated in her wheelchair with an over bed table placed in front of her in the dining/activity room. There was a blue foam ball placed on top of the tray. Hospital Aide (HA)3 went over to assist C3 to squeeze and hold onto the ball. The staff member walked away and C3 released the ball. -At 03:40 PM, C3 was seated in the dining/activity room. HA4 wheeled client out the door of the dining/activity room, turned around, and came back in. HA4 placed C3 at the nurses' station. -At 04:05 PM, C3 was observed in her room, seated in her wheelchair asleep. -At 04:20 PM, C3 was placed by the television in the dining/activity room. The Food Network was on and C3 was not facing the television. C3 was observed in the dining/activity room by the television until 05:20 PM. C3 was observed to intermittently close her eyes with her head hanging down. Prior to the dinner meal, C3 was placed in a smaller room next to the dining/activity room with C5. An over bed table was placed in front of them with an animated cartoon streaming on an ipad. C3 was observed to intermittently put her head down and close her eyes. There were no staff members present. Record review noted C3 was admitted to the facility on 08/01/19. Diagnoses include autosomal recessive	W0249		

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W0249	Continued from page 2 disorder, seizure disorder, and cerebral palsy. C3 receives nutrients via gastrostomy tube. A review of C3's active treatment program included: watering the plants (the goal to hold the watering can for 10 seconds); activate two keys on the piano keyboard during a 10-minute song session; engage in group activities for 13 minutes; and interact with peers and staff during a social activity (art, music, storytelling, outdoor) for at least 5 minutes. There was no observation of staff implementing an active treatment program for C3 from 03:16 PM to 06:00 PM.	W0249		
W0339	NURSING SERVICES CFR(s): 483.460(c)(4) Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide nursing services consistent with standard nursing practice and principles. Specifically, the facility failed to ensure enteral (tube-feeding) nutrition was appropriately labeled for the correct client through three feedings/uses. Proper labeling of enteral nutrition is an essential component of ensuring the correct intervention(s) are applied to the appropriate client. Findings include: On 07/07/23 at 09:13 AM, concurrent observation and interview was done with the Nurse Manager (NM) at the bedside of Client (C)5 to confirm when her enteral nutrition (tube-feeding) and administration set had last been replaced. Observed the tube feeding formula had been hung (the bag was punctured for use) on 07/06/23 at 02:20 PM. It was also noted that the identification label affixed to her tube-feeding formula bag had C1's name and enteral nutrition order on it. C1's ordered administration amount was exactly double what C5's ordered amount was. Asked NM how she could tell if the Nurses had administered the right amount at each feeding. NM answered that she hoped the Nurses went off the order and not the label.	W0339		

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W0339	Continued from page 3 Record review of C5's medical chart at this time confirmed that the enteral formula hung at her bedside was correct, and should have been administered at 100 milliliters (mls) per hour for a total of 165mls three times a day (at 06:00 AM, 02:00 PM, and 10:00 PM), to provide 495mls daily (per 24-hour period). At 09:36 AM, a second concurrent observation and interview with NM at C5's bedside was done. Observed there was approximately 500mls of enteral formula remaining in the 1000ml bag. NM stated C5 would have had three feedings since the new bag was hung, so 495ml total. NM acknowledged that although she had gone in herself to look at the bag, she did not notice that the label affixed by nursing had the wrong Client's name on it. Review of the facility's Enteral Feeding policy and procedure revealed the following under 5.3 Administration: "5.3.2 Confirm the formula with the resident-specific label reflects what is ordered by the physician."	W0339		
W0454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to provide a sanitary environment to avoid sources and transmission of infections, as evidenced by observation(s) made of a nurse dropping a covered tube-feeding tip on the floor, and continuing to use the same contaminated tip cover; and observations of a staff member not performing hand hygiene while changing a feces-soiled personal brief. As a result of this deficient practice, 2 of 5 clients sampled were placed at risk of disease transmission. Findings include: 1) On 07/05/23 at 04:04 PM, observed Registered	W0454		

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W0454	Continued from page 4 Nurse (RN)1 disconnect Client (C)5's tube-feeding, cover the tip with a plastic cover, and accidently drop it on the floor. RN1 then picked it up off the floor and without wiping it or changing the cover, placed the tube-feeding tip with the contaminated tip cover into the tube-feeding equipment bag at the bedside. At 04:05 PM, confirmed the observation with RN1 at C5's bedside. Concurrent observation at this time noted that the syringe used to flush C5's gastric tube was also stored in the tube-feeding equipment bag at the bedside. RN1 was then observed moving on to other tasks for a different client. No observation(s) made of RN1 replacing the tube-feeding equipment bag at C5's bedside with clean items or a clean bag. On 07/06/23 at 12:35 AM, an interview was done with the Nurse Manager (NM) at the Nurses' Station. When informed of the observations of RN1 from the previous afternoon, NM1 agreed that RN1 should have not placed the contaminated tube-feeding cover into the "clean" bag. 2) On 07/05/21 at 01:20 PM, observation was made of enhanced barrier precaution (transmission-based precautions requiring extra personal protective equipment) signage in C1's doorway. During an interview with the Infection Preventionist (IP) at the Nurses' Station at 01:45 PM, when questioned about the signage and expectations for staff, the IP stated that staff had been trained to don (put on) gloves and a gown when working directly and closely with a client, (such as when re-positioning or changing clothes). On 07/05/23 at 05:12 PM, observations were done at the bedside of C1. Hospital Aide (HA)1 was observed, while gloved, reconnecting C1's tracheal tube to oxygen. HA1 then changed her gloves and donned a new pair without performing hand hygiene. Without donning a gown, HA1 then began actively changing C1's disposable adult brief, which was soiled with soft, brown feces. Observed HA1 change her gloves three more times during the brief change, with no hand hygiene in between. On 07/06/23 at 12:35 AM, an interview was done with the Nurse Manager (NM) at the Nurses' Station. NM confirmed that staff are trained to conduct hand hygiene between glove changes. Stated the hand hygiene policy is part of the Infection Control policies and procedures. NM also confirmed that	W0454		

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W0454	Continued from page 5 HA1 should have been wearing a gown while changing C1's brief, as he is on enhanced barrier precautions.	W0454		