

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125003	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Kula Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Keokea Place Kula, HI 96790	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39853 Based on interviews, observation, record and document review, the facility failed to report two incidents that met criteria to the Department of Human Services, Adult Protective Services (APS) as required by law. P1 was found to have two large forearm lacerations/skin tears, and P2 was diagnosed with a broken finger. Both injuries did not have a known origin. P2 alleged his injury was caused by actions of a Certified Nursing Assistant (CNA)2. As a result of the is deficient practice, the State Agency, was not aware of the incidents and did not conduct external investigations. Findings include: 1) The Office of Healthcare Assurance (OHCA) received an initial facility reported incident (FRI # 11287), dated 10/27/2024. The report included: Details of the incident: Resident (R1) had a wound that needed to be assessed. The CNA (Certified Nurse Assistant)1 reported she noted it during care. Upon assessing the resident, RN (Registered Nurse)1 noted two large lacerations and bruising to the resident's left (Lt) forearm. Bruising was also noted to the resident's left upper arm. The interventions implemented included: Wounds assessed by RN, cleansed and physician notified. Resident sent to ED (Emergency Department) for treatment of injury. Police called to file a report. An investigation has been initiated and CNA1 has been placed on leave pending investigation. Full investigation to follow.The wounds required steri-strips and dry dressing as treatment. The initial report indicated the physician, responsible party, police, and administrator were notified of the incident on 10/27/2024. The report was marked NO, for Other agencies involved. OHCA received the completed report on 10/31/2024, which included Nursing continues to monitor healing progress of wounds and bruising. A thorough investigation was completed, including chart review, resident assessment, and staff/resident interviews. The findings of the investigation team are that the injury is the result of an accident during patient repositioning. R1 is a [AGE] year-old female admitted to the facility 010/2/2020. She has a history of of hypertension, coronary artery disease, dementia, and has short term and long-term memory deficit. Her BIMS (brief interview for mental status) is 0, severe cognitive impairment. R1 has been receiving hospice care since October 2022 and will remain in the facility long term. She is totally dependent on staff for activities of daily living. She requires 1 or 2 person assist for care and transfers, depending on her behavior, as she has displayed difficult behaviors when staff provide care. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete		Event ID: Facility ID: 125003
		If continuation sheet Page 1 of 4

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reviewed R1's medical records that included the following: Active care plan, prior to injury on 10/7/2924 included the Potential for impaired skin integrity r/t (related to) fragile skin. Nursing notes included, but not limited to skin assessments as follows: 09/04/2024 06:30 PM: weekly skin assessment performed.poor skin turgor. Bruise noted to L upper arm, approx. 2.5 cm 09/11/2024 12:10 PM: . poor turgor. Bruise on Lt upper arm subsided, approx. 1.5 cm and intact. 09/18/2025 05:45 PM: .Healed Rt arm bruise. 10/16/2024 11:30 AM: .BUE (bilateral upper extremities) with patches of discoloration. 10/23/2024 12:50 AM: .poor turgor. Lt arm with scattered bruises and discoloration to BU & LE (lower extremities). 10/27/2024 (Sunday) 07:00 AM: New skin tear to LFA (left forearm). Cleansed w(with)/normal saline and wrapped with gauze & kerlix. Hospice & Supervisor & Family notified. On 01/07/2025 at 02:35 PM, observed R1 in her bed. She was awake, appeared comfortable and well kept. She was wearing a long sleeve sweater, with Geri sleeves on, under the sweater for protection. R1 was calm, but shook her head no, when asked to examine her arms. She was not interviewable. Reviewed the ED (Emergency Department) Provider Notes, dated 10/27/2024 at 10:03 AM, for R1's ED visit. The physical exam revealed 2 skin tears, 1 is 7 cm (centimeters (1 centimeter is equal to 0.39 inches)), x 2 cm, 2nd skin tear is 5 cm x 1 cm, no active bleeding, some hematoma (localized collection of blood) under the larger skin tear. The provider documented R1 to be awake, demented, speech not so clear.Steri-strips (adhesive strips to help stabilize a wound) were applied to approximate the edges of the skin tear as best as possible. Pressure dressing and covering with gauze wrap applied. R1 was prescribed an antibiotic to prevent infection and transferred back to the long-term care facility. Reviewed the facility policy number 850-112-01 titled Abuse: Patient/Resident, last reviewed 03/08/2022. The policy included: 6.9.1 THE DAY THE ADMINISTRATOR OR DESIGNEE BECOMES AWARE OF THE ALLEGATION OF ABUSE AND REPORTS IT IS CONSIDERED DAY NUMBER 1 6.9.3 The Administrator (or Designee) shall during the day give an ORAL REPORT to: a. Department of Human Services, Adult Protective Services (APS) (if the victim is a dependent adult eighteen (18) years of age or older) . b. (1) Any alleged incident needs to be reported. If the facility is uncertain as to whether to report an incident, call APS/CPS (Child Protective Services) for assistance. (2) Calls to APS/CPS should be documented noting date and time called, name of person notified, and what was said. On 01/06/2025 at 02:00 PM, conducted an interview in the conference room with RN1, day shift nurse who was on duty when the event was reported. RN1 said she had received reports from staff in past, that R1 had combative behavior sometimes when they provide care. She said R1 sustains bruises and skin tears easily. RN1 said she had not yet received report from the night shift, when the day CNA radioed her to go to R1's room. She went on to say, when she saw R1, she was in bed and very calm. RN1 said R1 had a dressing on her left forearm, but it was soaked with fresh blood. She said she notified the House Supervisor (HS), to come and assess R1. RN1 said R1's skin tears were pretty big. She went on to say when the night nurse told her R1 had a skin tear, she asked how the injury occurred, and he said I don't know, I didn't ask the CNA. RN1 described the tears again as pretty deep, there were two lacerations. She said as far as she could remember, the bruise on upper arm had already been there, and didn't occur at same time. She said the injury could possibly have occurred the way she was grabbed. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/07/2025 at 09:15 AM, conducted a phone interview with the HS, who assessed R1. She said she received a call from the day shift RN, to come to the unit to look at a wound, that had been reported that morning. The HS said when she got to R1's room, the RN had already removed the bandage and she noted a big bruise on R1's left upper arm and two deep lacerations on the forearm. The HS described the wound like two sharp objects went through the skin. She said she noted The Chux (disposable underpad), under her, on the bed, had some dark blood saturated on the pad, thinking it was bleeding for a while. The HS went on to say, it was reported to her the night CNA didn't do rounds and had left the facility. The HS notified the DON, who told her We have to do the protocol, notify police, and do interviews. The HS said From my experience, it was not a regular skin tear, it was huge, it's a trauma, couldn't be from bump. She said she instructed the nurse to call the Hospice agency, who would notify the MD, and soon after, she received an order to send R1 to the ED for treatment. The HS said because R1 has frequent bruising, she reviewed the chart and found there was documentation of a previous bruise on the left upper arm, but no measurements were recorded. She said it (the bruise) looked like it was fresh to me as it was still red. If it had been from a week ago, it should have darker discoloration. It was red, bruising on edges, but the base of it appeared like it freshly happened. Asked the HS to expand on what the protocol was the DON referred to. She said it includes notifying the police within 24 hours, contacting the doctor, and starting the investigation. When inquired if calling Adult Protective Services was part of the protocol, she said yes, I think it should be. The HS said she did not notify APS that day. On 01/08/2025 at 10:00 AM, interviewed the DON in the conference room. She confirmed APS had not been notified. She went on to say the investigation was done quickly and it was determined there was not enough evidence to substantiate abuse, or that the CNA was rough' when caring for R1. The DON said they concluded the injury likely occurred during positioning and the CNA was inattentive to the her (R1's) safety needs. She said it was her understanding, if the facility investigation did not substantiate abuse, they were not required to report it to APS. 2) On 09/08/2024, OHCA received the initial report (ACTs # 11194), regarding an injury R2 received, of unknown origin on 09/08/2024. - Initial report included: Resident (R2) reported to RN that the black CNA pulled on my hand and it hurts. Resident unable to provide further specifics. Contusion noted to right first digit and palm. Injury was described as 2 cm contusion, edema, and erythema to dorsal base of first digit on right hand: 1 cm bruise to palmar surface of right hand. Interventions included Physician notified of injury. XR (x-ray) of right hand ordered. Investigation to follow. - Completed report dated 09/12/2024, included: R2 has a diagnosis of developmental delay and a history of verbally and physically aggressive behavior. Approximately 14:30, NA (CNA)2 entered R2's room to provide care an he immediately began yelling and swinging a plastic toy light [NAME] at CNA2. CNA3 was able to calm the resident, who then surrendered the light [NAME]. Both CNA2 and CNA3 completed incontinence care together.R2 told RN his right hand was sore.At 19:25, the finger was re-assessed again and it was noticeably more swollen, blue bruising apparent. At this time, R2 reported to RN that CNA2 grabbed him and pulled him up in bed while performing incontinence care. There are inconsistencies in R2s subsequent reports. He told the nurse manager that the nurse aid grabbed it and broke it in 2 like this while making a motion similar to breaking a pencil in half and she bent it down real hard until it broke. CNA2 states she did not pull on his finger, bend his finger, or pull him up in bed by his finger . (continued on next page)		

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