Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Callo Care Home	**CHAPTER 100.1**
Address: **1027 A Lowell Place, Honolulu, Hawaii 96817**	**Inspection Date: January 6, 2015 Annual**

	Rules (Criteria)	**Plan of Correction**	**Completion Date**
☒	§11-100.1-2 Definitions. As used in this chapter: "ARCH resident" means a person unrelated to the primary care giver and licensee who resides in an ARCH. Individuals residing in an ARCH require minimal assistance in the activities of daily living, and do not need assistance from skilled, professional personnel on a regular long-term basis. **FINDINGS** [redacted] ***Please have the residents' level of care reassessed by a physician and submit a copy with your plan of correction.***	[redacted] In the future, if there is a case like this again, the LOC assessment of the physician prior to admission of the resident must be followed.	5/10/15
☒	§11-100.1-10 Admission policies. (a) Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be	In the future, prior to admission of a resident, the level of care must be obtained from the physician or APRN.	5/10/15

	obtained prior to a resident's admission to a Type I ARCH and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's responsible placement agency, and others authorized by the resident to review it. **FINDINGS** [redacted]		
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** [redacted]	[redacted] To avoid the same mistake in the future, all orders made by the Doctor must be signed.	5/10/15
☒	§11-100.1-17 Records and reports. (a)(3) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Documentation of date of referral and admission, referral agency with address and telephone number, place or source from which admitted, physician, APRN, dentist, ophthalmologist, optometrist, psychiatrist, and all other medical or social service professionals who are currently treating the resident, next of kin, legal guardian,	[redacted] To avoid the same problem in the future, if there is a new medication order made by the doctor, I will make sure to write down right away on the medication record and in the patient's emergency form so that the patient's record is always updated in case of emergency or in case the patient is transferred.	5/10/15

	surrogate or other legally responsible agency; **FINDINGS** Resident #1, resident emergency information sheet did not list the current medications.		
☒	§11-100.1-17 Records and reports. (g) All information contained in the resident's record shall be confidential. Written consent of the resident, or resident's guardian or surrogate, shall be required for the release of information to persons not otherwise authorized to receive it. Records shall be secured against loss, destruction, defacement, tampering, or use by unauthorized persons. There shall be written policies governing access to, duplication of, and release of any information from the resident's record. Records shall be readily accessible and available to authorized department personnel for the purpose of determining compliance with the provisions of this chapter. **FINDINGS** [redacted]	[redacted] From now on, all patient's records are stored in a secured area because the information contained in the patient's binders are confidential.	5/10/15
☒	§11-100.1-83 Personnel and staffing requirements. (5) In addition to the requirements in subchapter 2 and 3: Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents. **FINDINGS** 1) Substitute care giver (SCG) [redacted] completed 9.5 of the required 12 hours of continuing education. ***Please submit documentation of an additional 2.5 hours of continuing education to be counted***	[redacted] From now on, I will update the SCG and myself with the required 12 hours of CE per year pertinent to the management of an Expanded ARCH and care of E-ARCH residents.	5/19/15

	towards your 2015 annual inspection. 2) SCG #2, no documentation of completion of twelve (12) continuing education hours. ***Please submit documentation of twelve (12) hours of continuing education to be counted towards your 2015 annual inspection.***		
☒	§11-100.1-84 Admission requirements. (b)(4) Upon admission of a resident, the expanded ARCH licensee shall have the following information: Evidence of current immunizations for pneumococcal and influenza as recommended by the ACIP; and a written care plan addressing resident problems and needs. **FINDINGS** Resident #1, no record of pneumococcal immunization.	I called the doctor regarding Nancy's pneumonia but they cannot provide because the hospital was the one who gave the pneumo vaccine. To avoid the same problem in the future, I will update the Immunization record at the time of admission.	5/10/15

Licensee/Administrator's Signature: Tessie A. Callo

Print Name: TESSIE A. CALLO

Date: 5/22/15

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☒	§11-100.1-2 Definitions. As used in this chapter: "ARCH resident" means a person unrelated to the primary care giver and licensee who resides in an ARCH. Individuals residing in an ARCH require minimal assistance in the activities of daily living, and do not need assistance from skilled, professional personnel on a regular long-term basis. **FINDINGS** [redacted] ***Please have the residents' level of care reassessed by a physician and submit a copy with your plan of correction.***	[redacted] In the future, an assessment of the LOC by the resident's physician should be obtained from the physician before admission.	5/21/15
☒	§11-100.1-10 Admission policies. (a) Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be		

	obtained prior to a resident's admission to a Type I ARCH and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's responsible placement agency, and others authorized by the resident to review it. **FINDINGS** [redacted]	[redacted] In the future, prior to admission of a resident, the level of care must be obtained from the physician or APRN.	5/21/15
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** [redacted]		
☒	§11-100.1-17 Records and reports. (a)(3) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Documentation of date of referral and admission, referral agency with address and telephone number, place or source from which admitted, physician, APRN, dentist, ophthalmologist, optometrist, psychiatrist, and all other medical or social service professionals who are currently treating the resident, next of kin, legal guardian,		

	surrogate or other legally responsible agency; **FINDINGS** [redacted] resident emergency information sheet did not list the current medications.		
☒	§11-100.1-17 Records and reports. (g) All information contained in the resident's record shall be confidential. Written consent of the resident, or resident's guardian or surrogate, shall be required for the release of information to persons not otherwise authorized to receive it. Records shall be secured against loss, destruction, defacement, tampering, or use by unauthorized persons. There shall be written policies governing access to, duplication of, and release of any information from the resident's record. Records shall be readily accessible and available to authorized department personnel for the purpose of determining compliance with the provisions of this chapter. **FINDINGS** Resident records stored unsecured on T.V. stand in resident living area.		
☒	§11-100.1-83 Personnel and staffing requirements. (5) In addition to the requirements in subchapter 2 and 3: Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents. **FINDINGS** 1) Substitute care giver (SCG) [redacted] completed 9.5 of the required 12 hours of continuing education. ***Please submit documentation of an additional 2.5 hours of continuing education to be counted***	We notified all substitute cargivers that to continue employment with Callo Care Home, they must complete all the required continuing education courses no later than December 31 of every year. With this policy in place, we are certain that all caregivers will comply with the requirements. All the remaining continuing education hours for have already been submitted.	5/21/15

	towards your 2015 annual inspection. 2) SCG [redacted] no documentation of completion of twelve (12) continuing education hours. ***Please submit documentation of twelve (12) hours of continuing education to be counted towards your 2015 annual inspection.***		
☒	§11-100.1-84 Admission requirements. (b)(4) Upon admission of a resident, the expanded ARCH licensee shall have the following information: Evidence of current immunizations for pneumococcal and influenza as recommended by the ACIP; and a written care plan addressing resident problems and needs. **FINDINGS** Resident [redacted] no record of pneumococcal immunization.	Since the doctor did not have a record of the immunization procedure done, we called the hospital who performed the pneumococcal immunization to request a copy of their record, which is now in the resident's binder. [redacted]	3/31/15

Licensee/Administrator's Signature: Jessie A. Callo

Print Name: JESSIE A. CALLO

Date: July 12, 2015