

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Manoa Senior Care, Inc.	CHAPTER 100.1
Address: 2872 Oahu Avenue, Honolulu, Hawaii 96822	Inspection Date: February 20, 2015 Annual

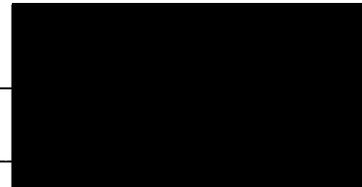
	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (k) Physician or APRN orders for nutritional supplements including vitamins, minerals, formula meals and thickening agents shall be updated annually or sooner as specified.</p> <p>FINDINGS</p> <p>[REDACTED]</p>	<p>DON reviewed with Nurses in the home and all the Nurses during the Manoa Senior Care Nurse meetings held on March 4 and 6, 2015 that all medications, treatments, and nutritional supplements need to be ordered by the physician or nurse practitioner before initiation.</p> <p>[REDACTED]</p>	<p>3/7/15</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p>FINDINGS</p> <p>[REDACTED]</p>	<p>[REDACTED]</p>	<p>3/7/15</p> <p>STATE OF HAWAII DEPARTMENT OF HEALTH MAY -4 P 1:46 RECEIVED</p>

	medications.		
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary.</p> <p>FINDINGS</p> 	<p>DON reviewed with Nurses in the home and all the Nurses during the Manoa Senior Care Nurse meetings held on March 4 and 6, 2015 that an "incident report", for significant/unusual circumstances affecting a resident, needs to be completed. Examples were provided. It was also reinforced to contact the DON/ADON if unsure whether one needs to be written.</p>	<p>3/6/15</p>

Licensee/Administrator's Signature: _____

Print Name: _____

Date: _____



4/30/15

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