

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Pohai Nani Ahui Olu	CHAPTER 100.1
Address: 45-090 Namoku Street, Kaneohe, Hawaii 96744	Inspection Date: October 14, 2015 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<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 [REDACTED]</p>		
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(7) During residence, records shall include:</p> <p>Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency;</p> <p>FINDINGS [REDACTED]</p>		

	Rules (Criteria)	Plan of Correction	Completion Date
	[REDACTED]		
☒	<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 [REDACTED]</p>		
☒	<p>§11-100.1-17 <u>Records and reports.</u> (h)(1) Miscellaneous records:</p> <p>A permanent general register shall be maintained to record all admissions and discharges of residents;</p> <p>FINDINGS [REDACTED] Permanent general register not maintained.</p>		
☒	<p>§11-100.1-20 <u>Resident health care standards.</u> (c) The primary and substitute care giver shall be able to recognize, record, and report to the resident's physician or APRN significant changes in the resident's health status including, but not limited to, convulsions, fever, sudden</p>		

	Rules (Criteria)	Plan of Correction	Completion Date
	weakness, persistent or recurring headaches, voice changes, coughing, shortness of breath, changes in behavior, swelling limbs, abnormal bleeding, or persistent or recurring pain. FINDINGS 		

Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____