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**
☒	§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**	Please see attachment	01/19/16
☒	§11-100.1-17 Records and reports. (b)(7) During residence, records shall include: Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency; **FINDINGS** No weight	Please see attachment	01/19/16

	Rules (Criteria)	Plan of Correction	Completion Date
	recorded [redacted].		
☒	§11-100.1-17 Records and reports. (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. **FINDINGS** Resident #1 No progress note for [redacted] incident report regarding [redacted]. No progress note for [redacted] incident report regarding [redacted].	see attachment Charting & Incident report Guidelines	01/19/16
☒	§11-100.1-17 Records and reports. (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** Resident #1 Admission [redacted] not reflected in permanent general register. Permanent general register not maintained.	Completed. See attachment	10/31/15
☒	§11-100.1-20 Resident health care standards. (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		

	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** [redacted] No documentation physician contacted [redacted]	Please see attachment Discussed via telephone conversation c Annette Jackson regarding attached statement	01/19/16

Licensee's/Administrator's Signature: [signature]

Print Name: Judith E. Matthews BSN RN

Date: 4.25.16

Licensee's/Administrator's Signature: [signature] Director ARCH/AL

Print Name: Judith E. Matthews

Date: 5-31-2016

Licensee's/Administrator's Signature: [signature]

Print Name: Judith E. Matthews RN Dir Health Svcs

Facility's Name: **POHAI NANI AHUI OLU**

Plan of Correction

RULES:

§11-100.1-17 Records and reports (b)(7)

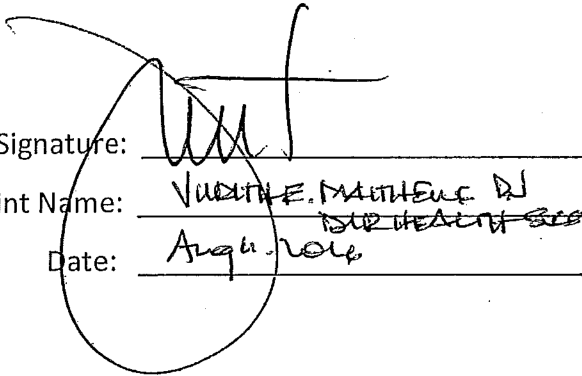
- Staff reeducated on weighing residents and need to notify RN manager and physician of changes. The step by step guidelines for obtaining weights, notifying physicians and ensuring that weights are done as ordered is now included in each ADL binder.
- All Physician/APRN orders will be transcribed to the MAR/TAR on the date received by the RN Care Home Manager

Completed on: 01/19/2016

Licensee's/ Administrator's Signature: ______

Print Name: ______

Date: ______



Facility's Name: **POHAI NANI AHUI OLU**

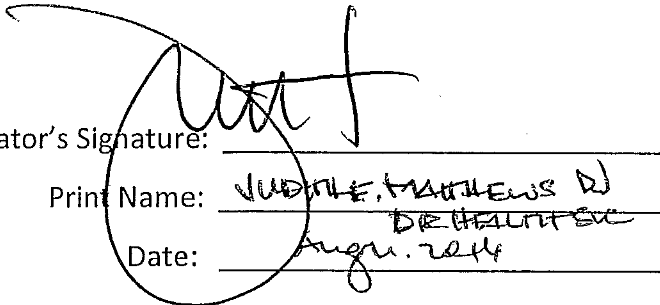
Plan of Correction

RULES:

§11-100.1-17 Records and reports (c)

- Staff reeducated on issues that must be charted on, including condition changes, progress notes and incident reports.
- Documentation guidelines have been placed in each ADL Binder. An in service on charting guidelines, incident reports and documentation has been added to the required training for the year.
- RN manager or designee will check all incident reports on a daily basis to ensure that progress notes are written.
- Progress notes will be written at the time of the occurrence and resident will be placed on alert charting for 72 hours. Alert charting requires each shift to document their observation of the resident for 72 hours. The RN will monitor all alert charts on a daily basis.
- The documentation guidelines include all forms of unusual occurrences and is used as a reference tool so that staff will know when to complete an incident report. Incident reports are made for all unusual occurrences.

Completed on: 01/19/2016



Licensee's/ Administrator's Signature: ______________

Print Name: ______________

Date: ______________

Facility's Name: **POHAI NANI AHUI OLU**

Plan of Correction

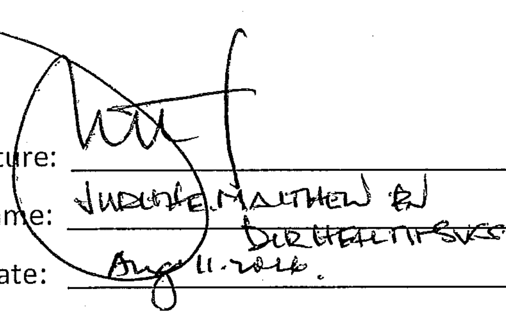
RULES:

§11-100.1-20 Resident health care standards (c)

- Staff has been reeducated on policy and method of reporting changes in weights to physicians.
- Staff will report all weight gains or losses to the RN care manager immediately based on the parameters established for that resident or facility policy. The RN Care Home manager will contact the physician immediately for additional orders and/or consultations with dietician as deemed necessary by the physician. The RN care home manger will document in the progress note all interventions at the time of occurrence.

Completed on: 01/19/2016

Licensee's/ Administrator's Signature:
Print Name:
Date:



Facility's Name: **POHAI NANI AHUI OLU**

Plan of Correction

RULES:

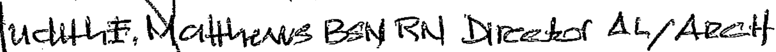
§11-100.1-17 Records and reports (c)

- Staff reeducated on issues that must be charted on, including condition changes, progress notes and incident reports.
- Documentation guidelines have been placed in each ADL Binder. An in service on charting guidelines, incident reports and documentation has been added to the required training for the year. See attachment 1B and 1C.

Completed on: 01/19/2016

Licensee's/ Administrator's Signature: ____________

Print Name: Judith F. Matthews BSN RN Director AL/ARCH



Date: 6.30.16

Facility's Name: **POHAI NANI AHUI OLU**

Plan of Correction

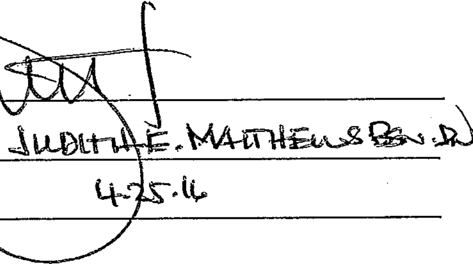
RULES:

§11-100.1-17 Records and reports (h)(l)

- Unit clerk reviewed register for errors and made corrections. See attachment 3D.
- All future admissions information will be re-checked by RN Manager and Unit Clerk for accuracy within 24 hours of entry into register. An admission checklist has been established for all new admissions and will be reviewed by RN Manager/designee within 24 hours of admission. See attachment 3E.

Completed on: 10/31/2015

Licensee's/ Administrator's Signature:



Print Name: JUDITH E. MATTHEWS RN

Date: 4.25.16