

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Hale Harmony	CHAPTER 100.1
Address: 1631 Owawa Street, Honolulu, Hawaii 96819	Inspection Date: October 4, 2016 Annual

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p><u>FINDINGS</u> Primary care givers (PCG) physical examination expired. Submit current copy with your plan of correction (POC).</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>PCG WENT TO THE PHYSICIAN ON 10/4/16 . OBTAINED THE PHYSICAL EXAMINATION & TB CLEARANCE .</p>	<p style="text-align: center;">10/4/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE #11-100.1-9(a)	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>EVERY QUARTER I WILL HAVE MY SCG + CG DOUBLE CHECK THE RECORDS TO MAKE SURE EVERYONE'S PHYSICAL EXAMINATIONS ARE UP TO DATE</p>	<p style="text-align: center;">10/4/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><u>FINDINGS</u> PCGs tuberculosis test expired. Submit current copy with your POC.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;">PCG WENT TO PHYSICIAN ON 10/4/16. OBTAINED TB CLEARANCE</p>	<p style="text-align: center;">10/4/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE #11-100.1-9(b)	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>EVERY QUARTER I WILL HAVE MY SCG & CG DOUBLE CHECK THE RECORDS TO MAKE SURE EVERYONE'S TB CLEARANCE IS UP TO DATE.</p>	<p style="text-align: center;">10/4/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (g) An inventory of all personal items brought into the Type I ARCH by the resident shall be maintained.</p> <p>FINDINGS Resident #1 list of possessions not completed on admission.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>RESIDENT #1 LIST OF POSSESSIONS WAS COMPLETED AND FILED IN THE CHART</p>	<p>10/6/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE #11-100.1-10(g)	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;">I WILL USE AN ADMISSION CHECK LIST AND COMPLETE THE LIST OF POSSESSIONS DATE OF ON ADMISSION.</p>	<p style="text-align: center;">10/6/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver.</p> <p><u>FINDINGS</u> Resident #1 physician orders reads.</p> <p>Medication not on October 2016 medication administration record.(MAR).</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>RESIDENT # 1'S MEDICATION WAS RECORDED IN OCTOBER 2016 MAR .</p>	<p style="text-align: center;">10/6/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>RULE #11-100.1-15(m)</p> <p><u>FINDINGS</u> Resident #1 physician orders reads, Medication not on October 2016 medication administration record.(MAR).</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I WILL USE SCG TO DOUBLE CHECK THAT I HAVE RECORDED ALL PHYSICIAN ORDERED MEDICATIONS INTO THE MAR.</p>	<p>10/6/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver.</p> <p><u>FINDINGS</u> Resident #1 physician orders reads Medication not on October 2016 MAR.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;">RESIDENT #1'S MEDICATION WAS RECORDED IN THE OCTOBER 2016 MAR.</p>	<p style="text-align: center;">10/6/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>RULE #11-100.1-15(m)</p> <p><u>FINDINGS</u> Resident #1 physician orders reads. Medication not on October 2016 MAR.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I WILL USE A SCG TO DOUBLE CHECK THAT I HAVE RECORDED ALL PHYSICIAN ORDERED MEDICATIONS IN THE MAR .</p>	<p>10/6/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver.</p> <p><u>FINDINGS</u> Resident #1 physician orders reads,</p> <p>Medication not on October 2016 MAR.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>RESIDENT #1'S MEDICATION WAS RECORDED IN THE OCTOBER 2016 MAR.</p>	<p>10/6/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>RULE #11-100.1-15(m)</p> <p><u>FINDINGS</u> Resident #1 physician orders reads</p> <p>Medication not on October 2016 MAR.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I WILL USE A SCG TO DOUBLE CHECK THAT I HAVE RECORDED ALL PHYSICIAN ORDERED MEDICATIONS IN THE MAR</p>	<p>10/6/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p><u>FINDINGS</u> Resident #1 no progress notes since admission.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE #11-100.1-17(b)(3)	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I WILL USE A CALENDAR TO CHECK THAT ALL PROGRESS NOTES ARE WRITTEN MONTHLY AND/OR IMMEDIATELY, IF AN INCIDENT HAS OCCURED.</p>	<p style="text-align: center;">10/6/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (e) In the event of an emergency, an oral summary of the resident's condition shall be provided to the receiving facility, followed by a written transfer summary.</p> <p><u>FINDINGS</u> Resident #1 emergency data sheet incorrect, medication doses not correct.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;">RESIDENT # 1'S DATA SHEET WAS CORRECTED REFLECTING PROPER MEDICATION DOSES.</p>	<p style="text-align: center;">10/6/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE #11-100.1-17(e)	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I WILL USE THE PHYSICIAN'S ORDERS TO DOUBLE CHECK THE MEDICATION DOSES .</p>	<p style="text-align: center;">10/6/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-19 <u>Resident accounts.</u> (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative.</p> <p><u>FINDINGS</u> Resident #1 no signed financial agreement signed during admission.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;">RESIDENT # 1S SIGNED THE FINANCIAL AGREEMENT AND WAS FILED IN THE CHART.</p>	<p style="text-align: center;">10/6/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE #11-100.1-19(a)	PART 2	
		<p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I WILL USE AN ADMISSION CHECK LIST TO COMPLETE THE FINANCIAL AGREEMENT UPON ADMISSION .</p>	10/6/16

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-84 <u>Admission requirements.</u> (b)(4) Upon admission of a resident, the expanded ARCH licensee shall have the following information:</p> <p>Evidence of current immunizations for pneumococcal and influenza as recommended by the ACIP; and a written care plan addressing resident problems and needs.</p> <p><u>FINDINGS</u> Resident #1 no evidence of pneumococcal immunization given or refused.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>RESIDENT # 1 WAS BROUGHT TO WALGREENS TO HAVE PNEUMOCOCCAL IMMUNIZATION DONE. FILED IN THE CHART. ATTACHED COPY:</p>	<p style="text-align: center;">10/20/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
☒	RULE #11-100.1-84(b)(4)	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I WILL USE AN ADMISSION CHECK LIST TO OBTAIN EVIDENCE OF IMMUNIZATIONS AND CARE PLAN UPON ADMISSION.</p>	10/6/16

Licensee's/Administrator's Signature: ~~Tina Rhodes Diaz~~ CHO

Print Name: TINA RHODES DIAZ

Date: OCTOBER 20, 2016