

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Alaag, L.L.C. ARCH	CHAPTER 100.1
Address: 94-1032 A Lumikula Street, Waipahu, Hawaii 96797	Inspection Date: June 10, 2015 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.</p> <p>FINDINGS Toxic chemicals and cleaning agents on open shelf in living room:</p> <ul style="list-style-type: none"> • Two (2) cans of insect spray • One (1) can spray paint • Old English cleaner • Pledge 	<p>I store all chemicals in a designated secured area away from food and clients. Limit access to chemicals by use of lock with key access. Store only chemicals that are necessary to the operation and maintenance of the kitchen. All other chemicals are kept outside the building in a secured area. On daily basis, I will conduct an inspection to ensure we are following the food and chemical safety regulations.</p>	6-10-15
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(1) 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:</p>	<p>Initial Admission Assessment of Resident 1 was completed on June 10, 2015. I revised the checklist for all new patient which includes admission, readmission, transfer and other important assessment requirement with specific scheduled</p>	6-10-15

	Rules (Criteria)	Plan of Correction	Completion Date
	<p>Documentation of primary care giver's assessment of resident upon admission;</p> <p>FINDINGS Resident #1:</p> <ul style="list-style-type: none"> No admission assessment by PCG for 9/27/14. 	<p>monthly and yearly deadline dates. Each scheduled date, I will conduct an audit of each patient's binder to ensure all the documents is compliant to standard protocol. In addition, I set my mobile phone to remind me at the end of the month, I complete the task mentioned above.</p>	
<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>FINDINGS Resident #1:</p> <ul style="list-style-type: none"> No documentation in progress notes for reason why PRN given once daily November 1-22, 2014. 	<p>The reason why given as PRN was documented in the progress note on June 10, 2015. I amended the progress note to include the PRN Medicine to avoid incomplete documentation on patient's binder. Since I am conducting an audit of each patient's binder monthly, this will prevent a recurrence of the deficiency.</p>	<p>6-10-15</p>

Licensee/Administrator's Signature: 

Print Name: LINDA GUTING

Date: Dec. 5, 2016