Office of Health Care Assurance

**State Licensing Section**

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| | |
|---|---|
| **Facility's Name:**<br><br>**Pohai Nani Ahui Laulea** | **CHAPTER 100.1** |
| **Address:**<br><br>**45-090 Namoku Street, Kaneohe, Hawaii 96744** | **Inspection Date:**<br><br>**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 |
|---|---|---|---|
| ☒ | §11-100.1-9 Personnel, staffing and family requirements.<br>(a)<br>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.<br><br>**FINDINGS**<br>Substitute care givers #3, #7, #14, #15, #27 No documentation of annual physical examination. | **PART 1**<br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>See attachment 1A | 11/01/16 |

1A

Facility Name: POHAI NANI Ahui Laulea

**Plan Of Correction**

RULES:
§11-100.1-9 Personnel Staffing and family requirements

**PART I CORRECTION FOR DEFICIENCY**

Physical examinations for substitute care givers # 3, # 7, #14, #15 and #27 completed by our Medical Director as of 11/01/16

Completion Date 11/01/16

Licensee's/Administrator's Signature _____

Print Name: Jedoth Matthew

Date: 11/04/16

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| ☒ | RULE # §11-100.1-9 (a) | **PART 2**<br>**FUTURE PLAN**<br><br>**USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**<br><br>See attachment 1B | 11/01/2016 |

1B

Facility Name: POHAI NANI Ahui Laulea

**Plan Of Correction**

RULES:
§11-100.1-9 Personnel Staffing and family requirements

**PART 2 FUTURE PLANS**

Unit Coordinator/or Designee will review files on a monthly basis to identify employees who require physical examinations to be done.
Unit coordinator will notify employees 4 weeks before physical is due and send employee forms To be completed and returned.
A follow-up remainder will be sent in 2 weeks if physical not completed and returned.
If not returned by end of 2 week period, will send weekly reminders to employee by phone and text messages.
If physical not completed by due date, employee will be removed from schedule until physical has been completed.

Completion Date 11/01/2016

Licensee's/Administrator's Signature _____

Print Name: Judith Matthew

Date: 11/04/16

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-9 Personnel, staffing and family requirements.<br>(b)<br>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.<br><br>**FINDINGS**<br>-Primary care giver No documentation of initial two-step PPD. Substitute care givers #1, #4, #5, #9, #10, #12, #15, #16, #20 #25, #30 no documentation of initial two-step PPD.<br>-Substitute care givers #5, #6, #7, #16, #28 no documentation of initial positive PPD<br>-Substitute care givers #9, #20 no documentation of annual TB clearance. | **PART 1**<br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>See attachment 2A | 11/01/16 |

2A

Facility Name: POHAI NANI Ahu Laulea

**Plan Of Correction**

RULES:
§11-100.1-9 (b) Personnel Staffing and family requirements

**PART 1 Correction of Deficiency**

Documentation for all Substitute care givers initial positive PPD and two step PPD 's have been obtained and placed in their files.
Annual TB clearances for all substitute care givers have been completed and placed in their files.

Completion Date 11/01/2016

Licensee's/Administrator's Signature _____

Print Name: Judith Matthew

Date: 11/04/16

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| ☒ | RULE # §11-100.1-9 (b) | **PART 2**<br>**FUTURE PLAN**<br><br>**USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**<br><br>See attachment 2B | 11/01/2016 |

Facility Name: POHAI NANI Ahui Laulea

**Plan Of Correction**

RULES:
§11-100.1-9 (b) Personnel Staffing and family requirements

**PART 2 FUTURE PLANS**

Unit Coordinator/or Designee will review files on a monthly basis to identify employees who require physical examinations to be done.
Unit coordinator will notify employees 4 weeks before TB testing is due and send employee forms To be completed and returned.
A follow-up remainder will be sent in 2 weeks if TB test not completed and returned.
If TB testl not completed by due date, employee will be removed from schedule until completed

Completion Date 11/01/2016

Licensee's/Administrator's Signature _____

Print Name: Judith Matthews

Date: 11/04/16

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-9 Personnel, staffing and family requirements. (f)(1)<br>The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:<br><br>Be currently certified in cardiopulmonary resuscitation;<br><br>**FINDINGS**<br>Substitute care giver #25 No documentation of CPR certification. | **PART 1**<br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>see Attachment 3A | 10/07/2016 |

3A

Facility Name: POHAI NANI Ahui Laulea

**Plan Of Correction**

RULES:
§11-100.1-9 (f) (1) Personnel Staffing and family requirements

**PART I CORRECTION FOR DEFICIENCY**

Substitute care giver # 25 provided a copy of CPR that expires 11/30/16 on October 7, 2016

Completion Date 10/07/2016

Licensee's/Administrator's Signature _____

Print Name: Judith Mathews

Date: 11/04/16

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| ☒ | RULE # §11-100.1-9 (f)(1) | **PART 2**<br>**FUTURE PLAN**<br><br>**USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**<br><br>See attachment 3B | 10/07/2016 |

Facility Name: POHAI NANI Ahui Laulea

**Plan Of Correction**

RULES:
§11-100.1-9 (f) (1) Personnel Staffing and family requirements

**PART 2 FUTURE PLANS**

Unit Coordinator/or Designee will review files on a monthly basis to identify employees who need to renew CPR.
Unit coordinator will notify employees 4 weeks before CPR I is due and the date of next available Class.
If CPR not completed by due date, employee will be removed from schedule until completed.

Completion Date 10/07/2016

Licensee's/Administrator's Signature _____

Print Name: Jud Matthews

Date: 11/04/16

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-17 Records and reports. (a)(4)<br>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:<br><br>A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;<br><br>**FINDINGS**<br>Resident #1 No documentation of physical examination prior to or on admission. | **PART 1**<br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>See attachment 4A | 10/14/16 |

Facility Name: POHAI NANI Ahui Laulea

**Plan Of Correction**

RULES:
§11-100.1-17 Records and Reports (a) (4)

**PART I CORRECTION FOR DEFICIENCY**

Physical examination was completed by physican prior to admission date was on second page, date has been clarified with physician

Completion Date 10/ 14/16

Licensee's/Administrator's Signature _____

Print Name: Judith Matthews

Date: 11/04/16

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| ☒ | RULE # §11-100.1-17 (a)(4) | **PART 2**<br>**FUTURE PLAN**<br><br>**USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**<br><br>See attachment 4B | 11/03/16 |

4B

Facility Name: POHAI NANI Ahui Laulea

**Plan Of Correction**

RULES:
§11-100.1-17 Records and reports (a) (4)

**PART 2 Future Plans**

CHO/Manager will review all admission data when received to make sure all pages have appropriate dates

Completion Date 11/03/16

Licensee's/Administrator's Signature _____

Print Name: Judith Martinez

Date: 11/04/16

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-86 Fire safety. (a)(3)<br>A Type I expanded ARCH shall be in compliance with existing fire safety standards for a Type I ARCH, as provided in section 11-100.1-23(b), and the following:<br><br>Fire drills shall be conducted and documented at least monthly under varied conditions and times of day;<br><br>**FINDINGS**<br>No documentation of fire drills 12/15, 4/16, 5/16, 6/16, 7/16 and 9/16. | **PART 1**<br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>see attachment 5A | 10/12/16 |

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Facility Name: POHAI NANI Ahui Laulea

**Plan Of Correction**

RULES:
§11-100.1-86 Fire Safety (a) (3)

**PART I CORRECTION FOR DEFICIENCY**

Copies of fire drills completed for Cottages F1 and F2 on the following dates 12/15, 4/16. 5/16/ 6/16/, 7/16 and 9/16 were requested from maintenance department and has been placed in each care home binder.

Completion Date: 10/12/16

Licensee's/Administrator's Signature _____

Print Name: Judith Matthew

Date: 11/04/16

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| ☒ | **RULE #** §11-100.1-86 (a)(3) | **PART 2**<br>**FUTURE PLAN**<br><br>**USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**<br><br>See Attachment 5B | 10/12/16 |

5B

Facility Name: POHAI NANI Ahui Laulea

**Plan Of Correction**

RULES:
§11-100.1-86 Fire Safety (a) (3)

**PART 2 FUTURE PLANS**

Maintenance department will send a copy of fire drills to CHO/Manager as soon as it is completed. If not received by CHO/ Manager or designee by 25th of month, CHO/Manageror designee will contact maintenance department for documentation.

Completion Date: 10/12/16

Licensee's/Administrator's Signature _____

Print Name: Judoth Matthews

Date: 11/04/16

Licensee's/Administrator's Signature: 

Print Name: Judith Matthews

Date: 11/04/16