

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Pohai Nani Ahui Malie	CHAPTER 100.1
Address: 45-090 Namoku Street, Kaneohe, Hawaii 96744	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> Substitute care givers #3, #7, #14, #15, #27 No documentation of annual physical examination.</p>	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>See attachment # 1A</i></p>	<p style="text-align: right;"><i>but</i> 11/10/16</p>

1A

Facility Name: POHAI NANI Ahui Maile

Plan Of Correction

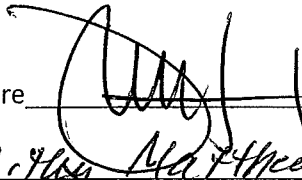
RULES:

§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: Judith M. Matthea
Date: 11/04/16

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-9 (a)	<p style="text-align: center;"> PART 2 <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>See attachment 1B</i> </p>	<p style="text-align: center;"> <i>11/01/2016</i> </p>

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Facility Name: POHAI NANI Ahui Maile

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.

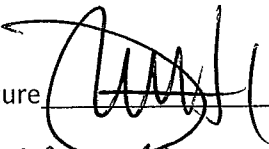
Unit coordinator will notify employees 4 weeks before physical is due and send employee forms To be completed and returned.

A follow-up reminder 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
<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> -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. -Substitute care givers #5, #6, #7, #16, #28 no documentation of initial positive PPD -Substitute care givers #9, #20 no documentation of annual TB clearance.</p>	<p style="text-align: center;">PART 1 <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;"><i>See attachment 2A</i></p>	<p style="text-align: center;"><i>11/01/2016</i></p>

2A

Facility Name: POHAI NANI Ahui Malie

Plan Of Correction

RULES:

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

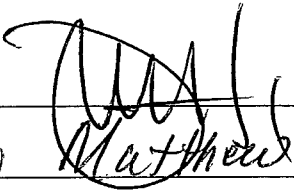
PART 1 Correction of Deficiency

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 Matthews

Date: _____

11/04/16

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-9 (b)	<p style="text-align: center;"> PART 2 <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>See attachment 2B</i> </p>	<p style="text-align: center;"> <i>11/01/16</i> </p>

Facility Name: POHAI NANI Ahui Malie

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.

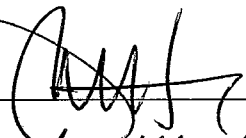
Unit coordinator will notify employees 4 weeks before TB testing is due and send employee forms To be completed and returned.

A follow-up reminder will be sent in 2 weeks if TB test not completed and returned.

If TB test 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
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:</p> <p>Be currently certified in cardiopulmonary resuscitation;</p> <p><u>FINDINGS</u> Substitute care giver #25 No documentation of CPR certification.</p>	<p style="text-align: center;">PART 1 <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;"><i>See attachment 3A</i></p>	<p style="text-align: center;"><i>10/07/2016</i></p>

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Facility Name: POHAI NANI Ahui Malie

Plan Of Correction

RULES:

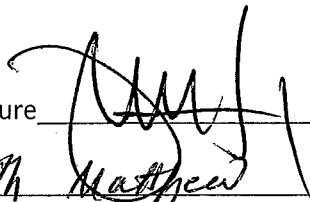
§11-100.1-9 (f) (1) Personnel Staffing and family requirements

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 Matthews

Date: _____

11/04/16

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-9 (f)(1)	<p style="text-align: center;"> PART 2 <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>See Attachment 3B</i> </p>	<p style="text-align: center;"> <i>10/07/2016</i> </p>

Facility Name: POHAI NANI Ahui Maile

Plan Of Correction

RULES:

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

PART 2 FUTURE PLANS

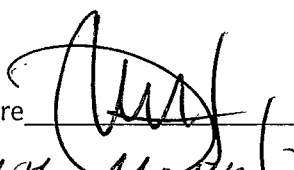
Unit Coordinator/or Designee will review files on a monthly basis to identify employees who need to renew CPR.

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: _____

Judith Matthews

Date: _____

11/04/16

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(8) During residence, records shall include:</p> <p>Notation of visits and consultations made to resident by other professional personnel as requested by the resident or the resident's physician or APRN;</p> <p><u>FINDINGS</u> Resident #1 No documentation by care giver noting physician visits on 7/8/16 and 8/3/16.</p>	<p style="text-align: center;">PART 1 <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;"><i>See attachment 4A</i></p>	<p style="text-align: center;"><i>10/17/16</i></p>

Facility Name: POHAI NANI Ahui Maile

Plan Of Correction

RULES:

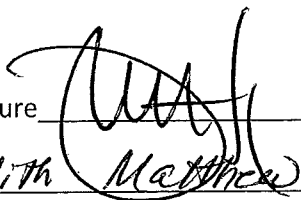
§11-100.1-17 Records and Reports (b) (8)

PART I CORRECTION FOR DEFICIENCY

Staff reeducated 10/17/16 on need to document in progress notes, visits for all providers that resident s are seen by on the day that resident returns from the visit.

Completion Date 10/17/16

Licensee's/Administrator's Signature _____



Print Name: _____

Judith Matthews

Date: _____

11/04/16

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-17 (b)(8)	<p style="text-align: center;"> PART 2 <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>See attachment 4B</i> </p>	<p style="text-align: center;"> <i>10/31/16</i> </p>

Facility Name: POHAI NANI Ahui Maile

Plan Of Correction

RULES:

§11-100.1-17 Records and Reports (b) (8)

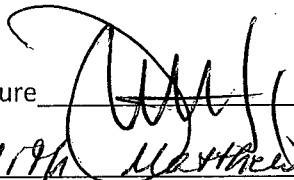
PART 2 Future Plans

Staff assigned to resident for that day will be responsible for documenting visits to provider in progress notes.

CHO/Manager and /or designee will check charts of all residents who have appointment on a daily basis to make sure documentation is being done.

Completion Date 10/31/16

Licensee's/Administrator's Signature _____



Print Name: _____

Judith Matthews

Date: _____

11/04/16

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<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><u>FINDINGS</u> Resident #1 No documentation in progress notes by care giver reflecting 8/24/16 resident wandering.</p>	<p style="text-align: center;">PART 1 <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;"><i>see attachment 5A</i></p>	<p style="text-align: center;"><i>10/10/16</i></p>

5A

Facility Name: POHAI NANI Ahui Malie

Plan Of Correction

RULES:

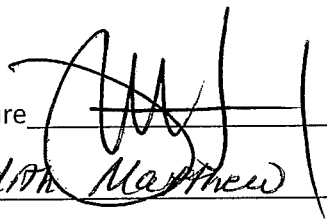
§11-100.1- 17 Records and reports (c)

PART I CORRECTION FOR DEFICIENCY

1:1 on training done with SCG # 9 and # 30 on 10/10/16 regarding documentation in progress notes when incident reports completed.

Completion Date: 10/10/16

Licensee's/Administrator's Signature



Print Name:

Judith Matthews

Date:

11/04/16

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-17 (c)	<p style="text-align: center;"> PART 2 <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>See attachment 5B</i> </p>	<p style="text-align: center;"> <i>10/17/16</i> </p>

Facility Name: POHAI NANI Ahui Malie

Plan Of Correction

RULES:

§11-100.1- 17 Records and reports (c)

PART 2 FUTURE PLANS

Staff reeducated on 10/17/16 on issues that must be charted.
Documentation guidelines have been placed in each ADL Binder.
CHO/Manager and /or designee will check incident reports on a daily basis to ensure that a progress note has been written at the time of the occurrence.
Executive Manager follow up will be completed on all incident reports within 72 hours using GSH form# 3425SL

Completion Date: 10/17/16

Licensee's/Administrator's Signature



Print Name:

Judith Matthews

Date:

11/04/16

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-86 <u>Fire safety.</u> (a)(3) 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:</p> <p>Fire drills shall be conducted and documented at least monthly under varied conditions and times of day;</p> <p><u>FINDINGS</u> No documentation of fire drills 12/15, 4/16, 5/16, 6/16, 7/16 and 9/16.</p>	<p style="text-align: center;">PART 1 <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;"><i>See Attachment 6A</i></p>	<p style="text-align: center;"><i>10/12/16</i></p>

6A

Facility Name: POHAI NANI Ahui Malie

Plan Of Correction

RULES:

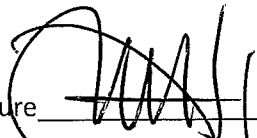
§11-100.1-86 Fire Safety (a) (3)

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: 11/08/16

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-86 (a)(3)	<p style="text-align: center;"> PART 2 <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>See attachment 6B</i> </p>	<p style="text-align: center;"> <i>10/12/16</i> </p>

Facility Name: POHAI NANI Ahui Maile

Plan Of Correction

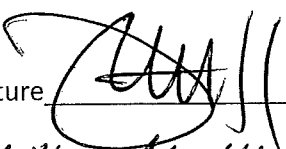
RULES:

§11-100.1-86 Fire Safety (a) (3)

PART 2 FUTURE PLANS

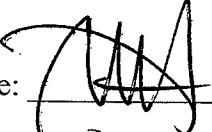
Maintenance department will send a copy of fire drills to CHO/Manager as soon as it is completed. If not received by CHO/ Manager or designee by 25th of month, CHO/Manager or designee will contact maintenance department for documentation.

Completion Date: 10/12/16

Licensee's/Administrator's Signature 

Print Name: Judith Matthew

Date: 11/04/16

Licensee's/Administrator's Signature: 
Print Name: Judith Matthew
Date: 11/04/16