

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name:</b>  <b>Pohai Nani Ahui Nani</b>	<b>CHAPTER 100.1</b>
<b>Address:</b>  <b>45-090 Namoku Street, Kaneohe, Hawaii 96744</b>	<b>Inspection Date:</b>  <b>October 5, 2016 Annual</b>

**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><b><u>FINDINGS</u></b>  Substitute care givers #3, #7, #14, #15, #27 no documentation of annual physical examination.</p>	<p style="text-align: center;"><b>PART 1</b>  <b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>See attachment 1A</i></p>	<p style="text-align: center;"><i>11/01/2016</i></p>

Facility Name: POHAI NANI Ahui Nani

Plan Of Correction

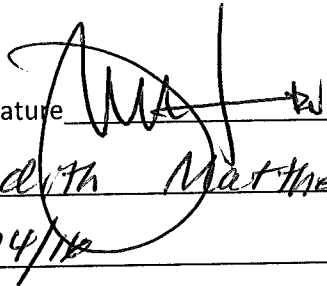
RULES:

§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 Matthew

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;"> <b>PART 2</b>  <b><u>FUTURE PLAN</u></b>   <b>USE THIS SPACE TO EXPLAIN YOUR            FUTURE PLAN: WHAT WILL YOU DO TO            ENSURE THAT IT DOESN'T HAPPEN            AGAIN?</b> </p> <p style="text-align: center;"><i>see Attachment 1B</i></p>	<p style="text-align: center;"><i>11/01/16</i></p>

Facility Name: POHAI NANI Ahui Nani

**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.

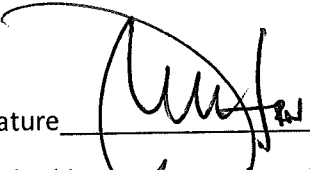
Unit coordinator will notify employees 4 weeks before physical is due and send employee forms To be completed and returned.

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><b><u>FINDINGS</u></b>            -Substitute Care Giver #12, no documentation of initial two-step PPD.            -Substitute Care Giver #16 no documentation of initial positive PPD            -Substitute Care Giver #9 no documentation of annual TB clearance.</p>	<p style="text-align: center;"><b>PART 1</b>  <b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>See attachment 2A</i></p>	<p style="text-align: center;"><i>11/01/14</i></p>

2A

Facility Name: POHAI NANI Ahu Nani

**Plan Of Correction**

RULES:

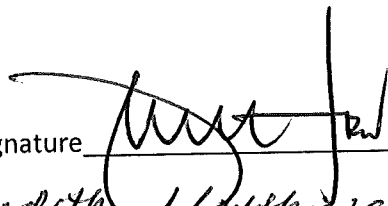
§11-100.1-9 (b) Personnel Staffing and family requirements

**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;"> <b>PART 2</b>  <b><u>FUTURE PLAN</u></b> </p> <p style="text-align: center;"> <b>USE THIS SPACE TO EXPLAIN YOUR            FUTURE PLAN: WHAT WILL YOU DO TO            ENSURE THAT IT DOESN'T HAPPEN            AGAIN?</b> </p> <p style="text-align: center;"> <i>See Attachment 2B</i> </p>	<p style="text-align: center;"> <i>11/07/14</i> </p>



Facility Name: POHAI NANI Ahui Nani

**Plan Of Correction**

RULES:

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

**PART 2 FUTURE PLANS**

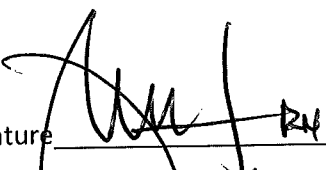
Unit Coordinator/or Designee will review files on a monthly basis to identify employees who require physical examinations to be done.

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><b><u>FINDINGS</u></b> Substitute Care Giver #25 No documentation of CPR certification.</p>	<p style="text-align: center;"><b>PART 1</b> <b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>See Attachment 3A</i></p>	<p style="text-align: center;"><i>10/07/16</i></p>

Facility Name: POHAI NANI Ahui Nani

Plan Of Correction

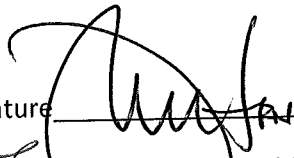
RULES:

§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;"> <b>PART 2</b>  <b><u>FUTURE PLAN</u></b> </p> <p style="text-align: center;"> <b>USE THIS SPACE TO EXPLAIN YOUR            FUTURE PLAN: WHAT WILL YOU DO TO            ENSURE THAT IT DOESN'T HAPPEN            AGAIN?</b> </p> <p style="text-align: center;"> <i>see attachment 3B</i> </p>	<p style="text-align: center;"> <i>10/07/16</i> </p>

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Facility Name: POHAI NANI Ahui Nani

**Plan Of Correction**

RULES:

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

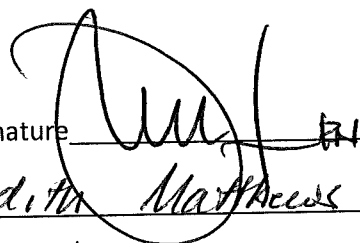
**PART 2 FUTURE PLANS**

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>§11-100.1-14 <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><b><u>FINDINGS</u></b>            Lysol spray unsecured in resident bathroom #1.</p>	<p style="text-align: center;"><b>PART 1</b>  <b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>see attachment 4A</i></p>	<p style="text-align: right;"><i>10/05/16</i>  <i>10/12/16</i></p>

4A

Facility Name: POHAI NANI Ahui Nani

**Plan Of Correction**

RULES:

§11-100.1- 14 Food Sanitation (1)

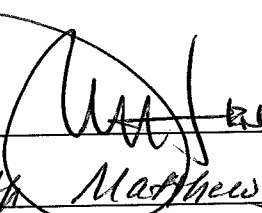
**PART I CORRECTION FOR DEFICIENCY**

Lysol removed from bathroom #1 immediately and placed in locked cabinet.  
Completion Date 10/05/16

Staff reeducated on not leaving chemicals in bathrooms (sprays) and to place all chemicals in locked cabinets at all times.

Completion Date: 10/12/16

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 # 11-100.1-14 (f)	<p style="text-align: center;"><b>PART 2</b> <b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p style="text-align: center;"><i>See Attachment 4B</i></p>	



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Facility Name: POHAI NANI Ahui Nani

**Plan Of Correction**

RULES:

§11-100.1- 14 Food Sanitation (1)

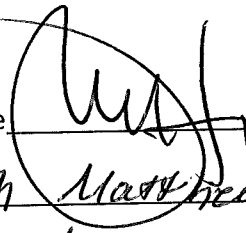
**PART 2 FUTURE PLANS**

Daily bathroom checks for chemicals and cleaning supplies have been added to each shift responsibility list to ensure that no chemicals or cleaning supplies are left in bathrooms.

CHO/Manager will monitor areas weekly x 1 month and then 2/month for 6 months and then monthly there after.

Completion Date 11/07/16

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>§11-100.1-15 <u>Medications</u>. (g)  All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year.</p> <p><b><u>FINDINGS</u></b>  No documentation of physician re-evaluations due 10/17/15, and 4/23/16.</p>	<p><b>PART 1</b>  <b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>see Attachment 5A</i></p>	<p><i>11/30/14</i></p>

5A

Facility Name: POHAI NANI Ahui Nani

**Plan Of Correction**

RULES:

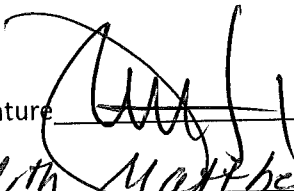
§11-100.1-15 Medications(g)

**PART I CORRECTION FOR DEFICIENCY**

Medical Director documented medication review on the 8/04/16 and will review medications in November on his quarterly visit.

Completion Date 11/30/16

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 # §11-100.1-15 (g)	<p style="text-align: center;"> <b>PART 2</b>  <b><u>FUTURE PLAN</u></b> </p> <p style="text-align: center;"> <b>USE THIS SPACE TO EXPLAIN YOUR            FUTURE PLAN: WHAT WILL YOU DO TO            ENSURE THAT IT DOESN'T HAPPEN            AGAIN?</b> </p> <p style="text-align: center;"> <i>See Attachment 5B</i> </p>	<p style="text-align: center;"> <i>11/03/16</i> </p>

5B

Facility Name: POHAI NANI Ahui Nani

**Plan Of Correction**

RULES:

§11-100.1-15 Medications(g)


**PART 2 Future Plans**

Resident will be seen by Medical Director in November and all medications will be reviewed.

CHO/ Manager will use Resident Medical Review form monthly to track the following for residents:

- Date of last Physical Examination
- Due Date of next physical Examination
- Date of last TB clearance
- Due Date of next TB clearance
- Date of Last MD and medication Review Visit
- Due date for next MD and medication review
- Date of last Dentist, Psychiatrist and other Specialty visits

Completion Date 11/03/16

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> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><b><u>FINDINGS</u></b> Resident #1 No documentation of annual physical examination due 6/16/16.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>See attachment <sup>CA</sup> SA error</i></p>	<p style="text-align: right;"><i>11/03/16 <sup>But</sup> error</i></p> <p style="text-align: right;"><i>10/07/16</i></p>

Facility Name: POHAI NANI Ahui Nani

**Plan Of Correction**

RULES:

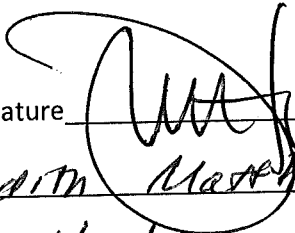
§11-100.1-17 Records and Reports (b) (1)

**PART I CORRECTION FOR DEFICIENCY**

Physical examination was completed by medical director on 08/04/2016

Completion Date 10/7/16

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)(1)	<p style="text-align: center;"> <b>PART 2</b>  <b><u>FUTURE PLAN</u></b> </p> <p style="text-align: center;"> <b>USE THIS SPACE TO EXPLAIN YOUR            FUTURE PLAN: WHAT WILL YOU DO TO            ENSURE THAT IT DOESN'T HAPPEN            AGAIN?</b> </p> <p style="text-align: center;"> <i>see attachment 6B</i> </p>	<p style="text-align: center;"> <i>11/03/16</i> </p>



Facility Name: POHAI NANI Ahui Nani

**Plan Of Correction**

**RULES:**

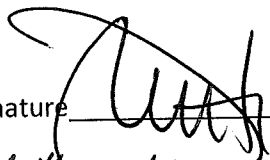
§11-100.1-17 Records and reports (b) (1)

**PART 2 Future Plans**

CHO/Manager will use Resident Medical Review form monthly to track the following for residents:

- Date of last Physical Examination
- Due Date of next physical Examination
- Date of last TB clearance
- Due Date of next TB clearance
- Date of Last MD and medication Review Visit
- Due date for next MD and medication review
- Date of last Dentist, Psychiatrist and other Specialty visits

Completion Date 11/03/16

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> (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><b><u>FINDINGS</u></b> Resident #1 No documentation by care giver noting physician visits on 11/14/15, 12/2/15, 12/18/15, 12/23/15, 1/11/16, 4/20/16, 7/9/16, 7/12/16, 9/26/16.</p>	<p style="text-align: center;"><b>PART 1</b> <b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>See Attachment 7A</i></p>	<p style="text-align: center;"><i>10/17/14</i></p>

Facility Name: POHAI NANI Ahui Nani

**Plan Of Correction**

**RULES:**

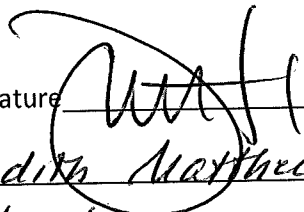
§11-100.1-17 Records and Reports (b) (8)

**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;"> <b>PART 2</b>  <b><u>FUTURE PLAN</u></b> </p> <p style="text-align: center;"> <b>USE THIS SPACE TO EXPLAIN YOUR            FUTURE PLAN: WHAT WILL YOU DO TO            ENSURE THAT IT DOESN'T HAPPEN            AGAIN?</b> </p> <p style="text-align: center;"> <i>see attachment 7B</i> </p>	

Facility Name: POHAI NANI Ahui Nani

**Plan Of Correction**

RULES:

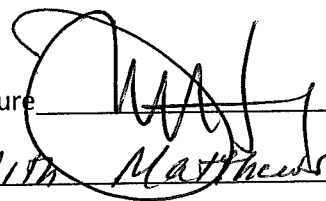
§11-100.1-17 Records and Reports (b) (8)

**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



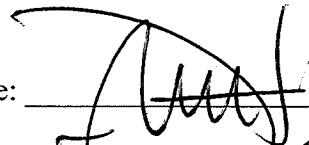
Print Name:

Judith Matthews

Date:

11/04/16

Licensee's/Administrator's Signature: \_\_\_\_\_



Print Name: \_\_\_\_\_

Judith Matthews

Date: \_\_\_\_\_

11/04/16