Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: 3J's	CHAPTER 100.1
Address: 1624 Perry Street, Honolulu, Hawaii 96819	Inspection Date: April 1, 2016 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. **FINDINGS** Substitute Care Givers #1, #2, #3 No documentation of training by primary care giver to make medications available and document such action.	CORRECTIVE ACTIONS: I ONLY HAVE (2) SUBSTITUTE ~~CAREGIVERS~~. THE (2) SUBSTITUTE CAREGIVERS HAVE BEEN TRAINED USING OHCA FORM, AND PUT IT ON MY ARCH OPERATOR BINDER. IF I TOOK LEAVE, ONE OF MY (2) SUBSTITUTE CAREGIVERS WILL BE THE ACTING PRIMARY CAREGIVER AND DURING MY ABSENT I WILL NOTIFIED THE OHCA, FAMILY MEMBERS AND CASE MANAGER AND INFORM THEY WHO WILL BE THE PRIMARY CAREGIVER. IF I HAVE NEW SUBSTITUTE CAREGIVER, I WILL BE RESPONSIBLE TO TRAINED HER/HIM USING OHCA TRAINING FORM, AND PUT IN ON MY FILE. IF ONE OF THE SUBSTITUTE CAREGIVER BECOME,	

1. For 11-100.1 **How?** The primary caregiver (me), I will ensure that all my substitute caregivers will have their on-hands training done on how to make the medications available to residents and shall be documented using my checklist. Please see attached "On-hands Medications Training Checklist".

For 11-100.1 **When (new caregiver)?** If I hire a new caregiver, the documentation of training and/or orientation around my care home surrounding shall be done right away using the OHCA training checklist (attached form) as my guidelines before the new caregiver able to work with my residents. During the training process, I will ensure to work with new substitute side by side until i feel that she/he pass all the required OHCA training checklist. If i feel that she/he passes all the required training given, I will sign the OHCA training checklist form that the new substitute caregiver has been accepted to work in my care home or with my residents. The documented training shall

☒	§11-100.1-17 Records and reports. (a)(8) 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:	CORRECTIVE ACTION: (RESIDENT #1 DECEASED ON APRIL 3, 2016) - I INVETORIED RESIDENT #1 PERSONAL BELONGINGS AND VALUABLES USING OHCA'S FORM.	

	Rules (Criteria)	Plan of Correction	Completion Date
	A current inventory of money and valuables. **FINDINGS** Resident#1 No current inventory of money and valuables.	FUTURE PLAN: I WILL ENSURE THAT I WILL INVETORY MY RESIDENT'S PERSONAL BELONGINGS & VALUABLES UPON ADMISSION OR/AND READMISSION USING OHCA FORM, WILL BE ADDED TO MY ADMISSION CHECKLIST FOR REMINDER	2 APR 2016

	Rules (Criteria)	Plan of Correction	Completion Date
	A current inventory of money and valuables. **FINDINGS** Resident#1 No current inventory of money and valuables.		
☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: 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; **FINDINGS** Resident#1 no documentation of changes in health status from ARCH level of care to ARCH expanded level of care/admission to hospice.	CORRECTIVE ACTION: (RESIDENT #1 DECEASED ON APR 3 2016) I MADE THE ENTRIES OF MY MONTHLY PROGRESS NOTES, AS LATE ENTRIES STARTING WHEN ~~SHE~~ SELF-PRESERVATION TO HOSPICE STATUS. FUTURE PLAN: I WILL MAKE SURE THAT I DOCUMENTED ON MY MONTHLY PROGRESS NOTES ALL OBSERVATION I NOTED ON MY RESIDENT AND WILL BE DOCUMENTED RIGHT AWAY, INCLUDING MY RESIDENT'S HEALTH CONDITION, AND BEHAVIOR.	2 APR 2016
☒	§11-100.1-17 Records and reports. (b)(8) During residence, records shall include: Notation of visits and consultations made to resident by other professional personnel as requested by the resident or the resident's physician or APRN; **FINDINGS** Resident#1 no documentation of physician office visits; 8/25/15, 8/31/15, 9/2/15, 9/17/15, 9/9/15, 9/17/15, 9/22/15, and 9/24/15.	CORRECTIVE ACTION: (RESIDENT #1 DECEASED ON 3 APR 2016) I MADE LATE ENTRIES ON MY MONTHLY PROGRESS NOTES REGARDING ALL MD'S VISITS. FUTURE PLAN: I WILL ENSURE TO BRING MY PROGRESS NOTES W/PHYSICIAN NOTES EVERYTIME I BRING MY RESIDENT FOR MD VISITS, AS MY REMINDER, AND DOCUMENT IT RIGHT AWAY	3 APR 2016

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-19 Resident accounts. (d) An accurate written accounting of resident's money and disbursements shall be kept on an ongoing basis, including receipts for expenditures, and a current inventory of resident's possessions. **FINDINGS** Resident#1 no ongoing inventory of money and valuables.	CORRECTIVE ACTION: (RESIDENT #1 DECEASED 3 APR 2016) I INVENTORIED RESIDENT #1 PERSONAL BELONGINGS AND VALUABLES RIGHT AWAY USING OHCA FORM. FUTURE PLAN: I WILL MAKE SURE THAT UPON ADMISSION OF MY RESIDENT I WILL DO THE INVETORIED RIGHT AWAY OF ALL BELONGINGS AND VALUABLES. I ALSO ADDED TO MY ADMISSION CHECKLIST.	2 APR 2016
☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(1)(C) Residents' rights and responsibilities: Written policies regarding the rights and responsibilities of residents during the stay in the Type I ARCH shall be established and a copy shall be provided to the resident and the resident's family, legal guardian, surrogate, sponsoring agency or representative payee, and to the public upon request. The Type I ARCH policies and procedures shall provide that each individual admitted shall: Be fully informed orally and in writing, prior to or at the time of admission, and during stay, of services available in or through the Type I ARCH and of related charges, including any charges for services not covered by the Type I ARCH's basic per diem rate; **FINDINGS** Resident #1 no specific charges for services rendered.	CORRECTIVE ACTION: I MADE A MEMORANDUM FOR ALL MY RESIDENTS' FAMILY FOR AKNOWLEDGEMENT OF THEIR LOVE ONE'S SERVICE CHARGES AS REQUIRED BY OHCA (MONTHLY SERVICE CHARGES). FUTURE PLAN: I WILL ADDED MONTHLY CHARGES ON MY ADMISSION CHECKLIST FOR AKNOWLEGEMENT AND AGREEMENT BETWEEN ME AND RESIDENT'S FAMILY	17 APR 2016
☒	§11-100.1-23 Physical environment. (g)(3)(I) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to,		

☒	§11-100.1-23 Physical environment. (g)(3)(I) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either: **FINDINGS** Resident#1, third non-self preserving resident.

Plan of Correction	Completion Date
FUTURE PLAN: I SHALL REQUEST IN WRITING TO OHCA ON ANY CONDITION IF MY RESIDENT CHANGE LEVEL OF CARE FROM SELF-PRESERVING TO NON-SELF PRESERVING AS MY THIRD EXPANDED RESIDENT. I WILL USE THE GUIDELINES GIVEN TO ME BY MY NURSE CONSULTANT for MY FUTURE REFERENCE.	2 APR 2016

CORRECTIVE ACTIONS: (RESIDENT #1 DECEASED 3 APR 2016)
I AM ABOUT TO WRITE A REQUEST (WAIVER) FOR MY THIRD EXPANDED EVEN THOUGH IT WILL NOT GET APPROVED BY OHCA, BUT THE RESIDENT PASSED AWAY 2 DAYS AFTER THE INSPECTION.

	Date
I KNOW I CANNOT HAVE (3) NON-PRESERVE IN MY CARE HOME FOR SAFETY REASON. FUTURE PLAN: ~~I SHALL NOT HAVE~~ I WILL ENSURE THAT IF I HAVE ONE OF MY ARCH CLIENT DEGRADED THE STATUS OF EXPANDED, I SHOULD REQUEST FOR MY 3RD EXPANDED IN MY CARE HOME UTILIZING OHCA FORM FOR MY GUIDELINES. BUT, IF THE 3RD CLIENT (EXPANDED) IS NON-PRESERVE I SHALL TRANSFER THE CLIENT RIGHT AWAY DUE TO SAFETY REASON. THREE NON-PRESERVE CLIENT IS NOT ALLOW IN LEVEL 1 CARE HOME.	1 AUG 16
CORRECTIVE ACTION: I SHALL NOT HAVE 3 EXPANDED CARE NON PRESERVE CLIENTS AT THE GIVEN TIME. I AM AWARE THAT I SHALL HAVE ONLY 2 EXPANDED CARE, I AM GUILTY OF WHAT I HAVE DONE. WHAT I SHOULD DO IS CALL MY NURSE CONSULTANT AND ASK ADVICE OF WHAT TO DO IF I HAVE 3RD CANDIDATE FOR EXPANDED CARE. THERE'S NO EXCUSE HERE ON MY PART. I SHOULD TRANSFER THE CLIENT ~~EVEN~~ (EXPANDED) TO OTHER CARE FACILITY OR I SHOULD REQUEST A WAIVER TO OHCA FOR MY 3RD EXPANDED, BUT IT WON'T GET APPROVE ANYWAY BECAUSE THE CLIENT IS NON-PRESERVE.	

☒	§11-100.1-23 Physical environment. (g)(3)(I) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions:

1 AUG 2016

(11-100.1-9) INACTIVE FOR A WHILE, AND HE/SHE DECIDED TO RETURN, I WILL ENSURE THAT TRAINING WILL BE [illegible]VIDED AGAIN TO REFRESH HER/HIS KNOWLEDGE [illegible]

	§11-100.1-88 Case management qualifications and services. (c)(6) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Coordinate care giver training, hospital discharge, respite, home transfers and other services as appropriate. Facilitate, advocate and mediate for expanded ARCH residents, care givers and service providers to ensure linkages and provision of quality care for the optimal function of the expanded ARCH resident; **FINDINGS** Resident #1, no documentation of training by the case manager of skills required for the care of the expanded ARCH level of care resident.	CORRECTIVE ACTIONS: (RESIDENT #1 DECEASED 3 APR 2016) ACQUIRED CARE PLAN FROM CASE MANAGER AND WILL BE PLACED TO RESIDENT'S BINDER. FUTURE PLAN: I WILL ENSURE THAT CARE PLAN WILL BE ACCURATE AND COMPLETE UPON RESIDENT'S ADMITTED TO EXPANDED CARE. THE REVIEW OF CARE PLAN WILL BE DONE BETWEEN ME AND THE CASE MANAGER. 17 APR 2016

For 11-100.1-88(c)(6) **Will do or not do?** If one of the caregivers documentation training not identified by nurse case manager, I shall get this caregiver **will do** the training as soon as possible using the skills checklist. If the training done then she/he able to do care to expanded ARCH resident. If the skills checklist not done, i will make sure that this caregiver **will not** do any care for expanded ARCH until the skills checklist is completed. 11 AUG 2016

2. For 11-100.1-88 (c)(6) **How?** The nurse case manager must evaluate or do the assessment first before admitting expanded ARCH. The primary caregiver and substitute caregivers shall be trained (on hand) by the nurse case manager as soon as possible before accepting expanded ARCH or within 24 hours of admission. The nurse case manager will develop a skills checklist that pertain to the care of expanded ARCH (see attached sheet for "sample "of nurse case manager checklist). This skill form shall be used by the nurse case manager to train (on-hand) us (primary/secondary caregivers).

For 11-100.1-88 (c)(6) **When?** I will ensure the documentation training (skills checklist) for expanded ARCH resident shall be completed, verified, and signed by the nurse case manager. I will check the skills checklist regularly or more often to ensure there's no changes or added to it, and i will ensure to notified the nurse case manager if the health status of resident changes, just in case, new skills training si needed. Then skills checklist of expanded ARCH resident shall be reviewed and updated for accuracy on a monthly basis at any time when nurse case manager visit . The skills checklist form shall be filed under the "case manager section" on expanded ARCH resident's binder.

☒ §11-100.1-88 Case management qualifications and services.
(c)(6)

Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:

Coordinate care giver training, hospital discharge, respite, home transfers and other services as appropriate. Facilitate, advocate and mediate for expanded ARCH residents, care givers and service providers to ensure linkages and provision of quality care for the optimal function of the expanded ARCH resident;

FINDINGS

Resident #1, no documentation of training by the case manager of skills required for the care of the expanded ARCH level of care resident.

CORRECTIVE ACTIONS: (1) MY INSPECTION WAS DONE ON APRIL 1, 2016. (2) MY CLIENT (#1) EXPIRED ON APRIL 3, 2016 (@ 0100) 2 DAYS AFTER MY INSPECTION. (3) I SUBMITTED MY POC ON APRIL 4, 2016 (HAND-CARRY TO OHCA). (4) I ACQUIRED CARE PLAN/SERVICE PLAN FROM MY CASE MANAGER ON APRIL 4, 2016, AND I RECEIVED IT ON APRIL 7. (5) CLIENT #1 CARE PLAN ~~AND~~ SERVICE PLAN IS IN PLACED ON CLIENT #1 DEAD FILE. (6) CLIENT #1 GOT APPROVED FOR HOSPICE ON MARCH 22.

MY FUTURE PLAN: (1) CLIENT NEEDS TO BE ASSESSED FOR EXPANDED CARE, IN ORDER TO ACCEPT CLIENT TO EXPANDED CARE I WILL ENSURE THAT CLIENT WILL BE EVALUATED BY MD OR APRN (2) IF THE MD/APRN APPROVED THE CLIENT ON EXPANDED STATUS, THE MD/APRN SHALL SIGNED CERTIFICATE OF LEVEL OF CARE (EXPANDED CARE), SELF PRESERVATION FORM (STATING THAT CLIENT IS NON-PRESERVATION STATUS). (3) IF THE CLIENT IS IN EXPANDED STATUS, ~~I WILL~~ CASE MANAGER IS REQUIRED. (4) THE CASE MANAGER WILL ~~DEVELOPED~~ CARE PLAN/SERVICE PLAN AND WE WILL REVIEW IT TOGETHER. (5) THE CASE MANAGER WILL TRAINED US INCLUDING MY SUBSTITUTES, THE [illegible] TANCE OF CARE PLAN/SERVICE PLAN. (6) ON EVERY SIX MONTHS THE CASE MANAGER REASSESS THE CLIENT AND UPDATED CARE PLAN/SERVICE PLAN IF NEEDED THEN [illegible] REQUIRED FOR THE CARE OF EXP[illegible]

[Handwritten in left margin:] ... SERVICE PLAN IS ATTACHED. – I RECVD ~~POC~~ THIS POC [illegible] ON JULY 29, 2016. – THANK YOU. HOPE THIS WILL SATISFIES THE REQUIRED CORRECTION. [signature] AUG 1 2016

Licensee's/Administrator's Signature:

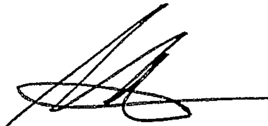
Print Name: Geronimo Castillo

Date: 17 Aug 2016

Licensee's/Administrator's Signature:

Print Name: Geronimo Castillo

Date: 1 AUG 2016

Licensee's/Administrator's Signature: 

Print Name: Geronimo Castillo

Date: 11 AUG 2016