Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: **Ohanalani L.L.C.**	**CHAPTER 100.1**
Address: **5339 Oio Drive, Honolulu, Hawaii 96821**	**Inspection Date:** **October 14, 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. (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. **FINDINGS** Substitute care givers #2, #3, #4 and Household member #3 No documentation of initial two-step TB clearance.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Reviewed all the SCG's records and household member #3. Pulled all the first and second TB clearances and placed in their folders.	10-14-16

	Rules (Criteria)	Plan of Correction	Completion Date
☒	RULE # §11-100.1-9 (b)	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future I will make sure that all the caregivers and household members initial and second step TB clearances are in their current folder and filed in the carehome folder. I will make sure that all new staff has it before they get hired. I will check all TB clearance records every 6 months prior to annual survey.	10/14/16

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§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 by care giver reflecting response to Anusol HC 2.5% PRN TID made available 10/5/16, and 10/6/16.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Checked the missed documentation and completed charting. Checked all the other medication administration record also.	10-14-16

	Rules (Criteria)	Plan of Correction	Completion Date
☒	RULE # §11-100.1-17 (b)(3)	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future, I will double check the medication administration record for completeness of charting. I assigned another caregiver to check the medication record and residents records monthly to ensure that charting is complete.	10-14-16

Licensee's/Administrator's Signature: Nora V. Soriano-Trias

Print Name: NORA V. SORIANO-TRIAS

Date: 2/10/17