

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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| Facility's Name: Senior Living with Aloha, L.L.C. | CHAPTER 100.1 |
| Address: 1419A 16 th Avenue, Honolulu, Hawaii 96816 | Inspection Date: March 30, 2017 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.

Handwritten notes:
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| | Rules (Criteria) | Plan of Correction | Completion Date |
|-------------------------------------|--|--|--|
| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (b)(7) During residence, records shall include:</p> <p>Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency;</p> <p><u>FINDINGS</u> Resident #1 no weights done over the last year due to bed bound status. No physician order to not weight resident, and no alternative measures to assess resident weight over the last year completed.</p> | <p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u> <i>Yes</i></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Called resident's doctor (Queen's Geriatric) and told about this citation.</i></p> <p><i>We were advised that a doctor's order will be issued <u>NOT</u> to weight resident due to resident's limitations.</i></p> <p><i>Unfortunately, resident passed away shortly on May 4, 2017.</i></p> | <p style="text-align: center;">4/7/2017</p> <p style="text-align: right;">77 50</p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (b)(7) During residence, records shall include:</p> <p>Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency;</p> <p><u>FINDINGS</u> Resident #1 no weights done over the last year due to bed bound status. No physician order to not weight resident, and no alternative measures to assess resident weight over the last year completed.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future, we will consult with the physician either to get an order to <u>NOT</u> weigh resident if appropriate or use alternative measure such as girth measure to assess resident weight on a monthly basis.</i></p> | <p>4/7/2017</p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-84 <u>Admission requirements</u>, (b)(4) Upon admission of a resident, the expanded ARCH licensee shall have the following information:</p> <p>Evidence of current immunizations for pneumococcal and influenza as recommended by the ACIP; and a written care plan addressing resident problems and needs.</p> <p>FINDINGS Resident #1 no record of pneumococcal immunization and no evidence of resident refusal.</p> | <p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;"><i>Yes</i></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Called resident's daughter who has the Power of Health Care Directive for the resident and mentioned to her about this deficiency.</i></p> <p><i>Resident's daughter then mentioned that she <u>doesn't</u> want to administer pneumococcal immunization to her [redacted] at this advanced stage of her [redacted].</i></p> <p><i>Unfortunately, resident passed away shortly on May 4, 2017</i></p> | <p style="text-align: center;"><i>4/7/2017</i></p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-84 <u>Admission requirements.</u> (b)(4) Upon admission of a resident, the expanded ARCH licensee shall have the following information:</p> <p>Evidence of current immunizations for pneumococcal and influenza as recommended by the ACIP; and a written care plan addressing resident problems and needs.</p> <p><u>FINDINGS</u> Resident #1 no record of pneumococcal immunization and no evidence of resident refusal.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>In the future, pneumococcal immunization will ^{will be} provided to all residents on a regular basis. A checklist of residents immunizations will be used to accomplish this.</p> <p>In case of resident refusal, we will secure an evidence of their refusal in writing.</p> | <p>4/7/2017</p> |

| | Rules (Criteria) | Plan of Correction | Completion Date |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(9) 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:</p> <p>Provide ongoing evaluation and monitoring of the expanded ARCH resident's status, care giver's skills, competency and quality of services being provided;</p> <p>FINDINGS Resident #1 no evidence of case manager ongoing evaluation of care givers skill and competency and no training completed by case manager for special care such as suctioning and alternative ways to monitor weight when a scale cannot be used.</p> | <p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u> Yes</p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Called the Case Manager and mentioned to her about this deficiency. Told her that during her next visit, we will discuss all training required and complete all required training as soon as she can. i.e. asap.</i></p> <p><i>Unfortunately, resident passed away shortly on May 4, 2017.</i></p> | <p>4/7/2017</p> |

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Licensee's/Administrator's Signature: Muhammad Jan Rumi

Print Name: M. JAN Rumi

Date: July 6, 2017

Umsino A. L. ...

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