

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name:</b> Oceanside Hawaii Assisted Living	CHAPTER 100.1
<b>Address:</b> 53-594 Kamehameha Highway, Hauula, Hawaii 96717	<b>Inspection Date:</b> January 18 & 19, 2017 Biennial

**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>§11-90-3 <u>Licensing</u>. (f)            In the event of a change of name, location, ownership, or licensed occupancy, the director shall be notified fifteen days prior to the change; an inspection at the discretion of the director shall be conducted and, if the provisions of this chapter are met, a new license issued.</p> <p><b><u>FINDINGS</u></b>            Name of facility changed to "Dignity Senior Living at Oceanside Hawaii" and ownership of facility has changed without any notice given to the Office of Health Care Assurance.</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;">A letter written by CEO was sent via certified mail to OHEA to notify change of ownership            see attachment A</p>	<p>1/25/17</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-90-3 (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>CEO will notify potential new owner(s) to ensure proper transition in a timely manner which is 15 days prior to the change of name, location, ownership or licensed occupancy.</p>	1/23/17

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-90-6 <u>General policies, practices, and administration.</u> (b) All facility staff shall be in compliance with current department tuberculosis clearance procedures.</p> <p><b><u>FINDINGS</u></b> Resident #1 no record of 2-step tuberculosis test (TB) completed prior to admission.</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;">Facility contacted physician to confirm that resident has completed a 2 step PPD prior to admission</p>	<p>1/20/17</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p><b>RULE # §11-90-6 (b)</b></p> <p><b><u>FINDINGS</u></b> Resident #1 no record of 2-step tuberculosis test (TB) completed prior to admission.</p>	<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>Facility will create an admission checklist to ensure that a 2-step PPD is completed prior to admission in record.</p> <p>Admission coordinator will ensure items on admission checklist are completed prior to admission under the supervision of executive director.</p>	1/20/17

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-90-6 <u>General policies, practices, and administration.</u>            (b)            All facility staff shall be in compliance with current department tuberculosis clearance procedures.</p> <p><b><u>FINDINGS</u></b>            Resident #2 no record of 2-step TB completed. 2015 attestation states, "History of positive TB." 2016 skin test results are 0.0 mm. Clarify resident TB status.</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>facility contacted physician to confirm history of a positive PPD and negative xray.</i> </p>	<p><i>1/20/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p><b>RULE # §11-90-6 (b)</b></p> <p><b><u>FINDINGS</u></b>  Resident #2 no record of 2-step TB completed. 2015 attestation states, "History of positive TB." 2016 skin test results are 0.0 mm. Clarify resident TB status.</p>	<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;">Facility created weekly Executive Directors Report to indicate residents TB status which will be reviewed by Executive Director and Care Coordinator or designee.</p>	1/20/17

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-90-6 <u>General policies, practices, and administration.</u> (d) The facility shall have written policies and procedures which incorporate the assisted living principles of individuality, independence, dignity, privacy, choice, and home-like environment.</p> <p><b><u>FINDINGS</u></b> Resident #1 service plan not reviewed and changed after significant change in resident status from self-administered medication to no longer being allowed to self-administer her own medications per policy 2-27.</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>Facility reviewed service plan and made appropriate changes to indicate residents status from self-administered medication to medication assistance. Reviewed service with resident and responsible party.</p>	<p style="text-align: center;">1/22/17</p>



	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p><b>RULE # §11-90-6 (d)</b></p> <p><b><u>FINDINGS</u></b>  Resident #1 service plan not reviewed and changed after significant change in resident status from self-administered medication to no longer being allowed to self-administer her own medications per policy 2-27.</p>	<p align="center"><b>PART 2</b> <b><u>FUTURE PLAN</u></b></p> <p 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>Facility will add items: change of condition of residents and change of service plan to reflect such a change to the weekly Executive Director report. Executive Director and Care Coordinator will ensure service plans are reviewed and changed after significant changes in residents status and condition.</p>	<p align="center">1/20/17</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-90-6 <u>General policies, practices, and administration.</u> (d) The facility shall have written policies and procedures which incorporate the assisted living principles of individuality, independence, dignity, privacy, choice, and home-like environment.</p> <p><b><u>FINDINGS</u></b> Resident #1 no incident reports generated for 1/16/17 skin tear, 11/8/16 fall, and 9/20/16 abdomen wound (bug bite) per policy 2-17.</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>Incident reports were generated for 11/20/17, 11/8/16 and 9/20/16.</i></p>	<p><i>11/20/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p><b>RULE # §11-90-6 (d)</b></p> <p><b><u>FINDINGS</u></b>  Resident #1 no incident reports generated for 1/16/17 skin tear, 11/8/16 fall, and 9/20/16 abdomen wound (bug bite) per policy 2-17.</p>	<p><b>PART 2</b>  <b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>Facility reviewed policy #2-17 and in serviced and educated all staff to properly report and complete incident reports. Facility will utilize incident report checklist to be reviewed by Executive Director, Care Coordinator or designee.</p>	<p>1/20/17</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-90-8 <u>Range of services.</u> (a)(1) Service plan.</p> <p>The assisted living facility staff shall conduct a comprehensive assessment of each resident's needs, plan and implement responsive services, maintain and update resident records as needed, and periodically evaluate results of the plan. The plan shall reflect the assessed needs of the resident and resident choices, including resident's level of involvement; support principles of dignity, privacy, choice, individuality, independence, and home-like environment; and shall include significant others who participate in the delivery of services;</p> <p><b><u>FINDINGS</u></b> Initial comprehensive assessments and all assessments prior to the last quarter of 2016 not available for inspection.</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;">Initial comprehensive assessment and all assessments prior to last quarter of 2016 were not made available thru transition to new ownership.</p>	<p>11/20/17</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-90-8 (a)(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>The facility will electronically scan all medical record such as, the initial comprehensive assessments and all assessments and store in an independant hard drive for 7 years before archive. Such electronically stored record will be made available for future change of ownership or whenever necessary.</p>	

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-90-8 <u>Range of services.</u> (a)(3) Service plan.</p> <p>The initial service plan shall be developed prior to the time the resident moves into the facility and shall be revised if needed within 30 days. The service plan shall be reviewed and updated by the facility, the resident, and others as designated by the resident at least annually or more often as needed;</p> <p><b><u>FINDINGS</u></b> Initial service plans for multiple resident not available for inspection.</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>Initial service plans prior to the change of ownership, were not made available to new owners during transition.</p>	<p>1/20/17</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p><b>RULE # §11-90-8 (a)(3)</b></p> <p><b><u>FINDINGS</u></b> Initial service plans for multiple resident not available for inspection.</p>	<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>The facility will electronically scan all medical record such as the initial service plans and store in an independant hard drive for 7 years before archive. Such electronically stored record will be made available for future change of ownership or whenever necessary.</p>	

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-90-8 <u>Range of services.</u> (a)(3) Service plan.</p> <p>The initial service plan shall be developed prior to the time the resident moves into the facility and shall be revised if needed within 30 days. The service plan shall be reviewed and updated by the facility, the resident, and others as designated by the resident at least annually or more often as needed;</p> <p><b><u>FINDINGS</u></b> Service plan updates prior to September 2016 not available for inspection for multiple residents.</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>Service plan updates prior to 6/30/16 were not made available thru transition to new ownership.</p>	11/20/17



	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p><b>RULE # §11-90-8 (a)(3)</b></p> <p><b><u>FINDINGS</u></b>            Service plan updates prior to September 2016 not available for inspection for multiple residents.</p>	<p align="center"><b>PART 2</b> <b><u>FUTURE PLAN</u></b></p> <p 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>The facility will electronically scan all medical record such as the service plan updates and store in an independent hard drive for 7 years before archive. Such electronically stored record will be made available for future change of ownership or whenever necessary.</p>	

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-90-8 <u>Range of services.</u> (b)(1)(B) Services.</p> <p>The assisted living facility shall provide the following:</p> <p>Three meals daily, seven days a week, including modified diets and snacks which have been evaluated and approved by a dietitian on a semi-annual basis and are appropriate to residents' needs and choices;</p> <p><b><u>FINDINGS</u></b>            No documentation that menus used prior to last quarter of 2016 were evaluated and approved by a dietitian.</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>Facility contacted registered dietician to review and approve 6 week menu cycle.</p>	<p>1/20/17</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-90-8 (b)(1)(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>Facility will follow Registered Dietitians approved 6 week menu cycle.</p>	1/20/17

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-90-9 <u>Record and reports system</u>: (a)(4)            The facility shall establish policies and procedures to maintain a system of records and reports which shall include the following:</p> <p>Incident reports of any bodily injury or other unusual circumstances affecting a resident which occurs within the facility, on the premises, or elsewhere, shall be retained by the facility under separate cover, and be available to authorized personnel and the department. The resident's physician or primary care provider shall be called immediately if medical care is necessary or indicated.</p> <p><b><u>FINDINGS</u></b>            Incident reports for 2015 and first three quarters of 2016 not available for inspection.</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>Incident reports prior to last quarter of 2016 were not available during transition to new owners.</i></p>	<p><i>1/20/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-90-9 (a)(4)	<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>The facility will electronically scan all medical records such as the incident reports and store in an independent hard drive for 7 years before archive. Such electronically stored records will be made available for future change of ownership or whenever necessary.</p>	

Licensee's/Administrator's Signature:



Print Name:

Albert Chen

Date:

02/02/2017

Licensee's/Administrator's Signature:



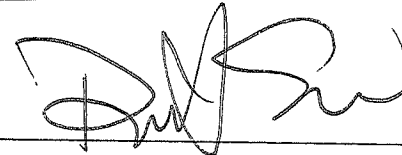
Print Name:

Albert Chen

Date:

7/19/2017

Licensee's/Administrator's Signature:



Print Name:

DAVID SU

Date:

02/11/2018