

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Nods	CHAPTER 100.1
Address: 689 Holua Drive, Kahului, Hawaii 96732	Inspection Date: April 6, 2018 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.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-8 <u>Primary care giver qualifications.</u> (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall:</p> <p>Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current;</p> <p><u>FINDINGS</u> PCG – No training sessions completed within the last year. <u>Repeat deficiency from 2017.</u></p>	<p>PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-8 <u>Primary care giver qualifications.</u> (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall:</p> <p>Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current;</p> <p><u>FINDINGS</u> PCG – No training sessions completed within the past year. <u>Repeat deficiency from 2017.</u></p>	<p>PART 2 <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>	

	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><u>FINDINGS</u> PCG, SCG #1 and #2 – No current annual physical exam. <u>Repeat deficiency from 2017.</u></p>	<p>PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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	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><u>FINDINGS</u> PCG and SCG #2 – No annual tuberculosis clearance. <u>Repeat deficiency from 2017.</u></p>	<p>PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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<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><u>FINDINGS</u> PCG and SCG #2 – No annual tuberculosis clearance. <u>Repeat deficiency from 2017.</u></p>	<p>PART 2 <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>	

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p><u>FINDINGS</u> PCG, SCG #1 and #2 – No current first aid certification. <u>Repeat deficiency from 2017.</u></p>	<p>PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><u>FINDINGS</u> No documentation that PCG trained SCG #1 and #2 to make prescribed medications available to residents. <u>Repeat deficiency from 2017.</u></p>	<p>PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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	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><u>FINDINGS</u> PCG, SCG #1 and #2 – No current cardiopulmonary resuscitation certification. <u>Repeat deficiency from 2017.</u></p>	<p>PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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<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><u>FINDINGS</u> PCG, SCG #1 and #2 – No current cardiopulmonary resuscitation certification. <u>Repeat deficiency from 2017.</u></p>	<p>PART 2 <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>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (g) An inventory of all personal items brought into the Type I ARCH by the resident shall be maintained.</p> <p><u>FINDINGS</u> Resident #1 – Inventory of all personal items not maintained.</p>	<p>PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit.</p> <p><u>FINDINGS</u> Resident #1 – No annual diet order signed by the physician.</p>	<p>PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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☒	<p>§11-100.1-15 <u>Medications</u>. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Physician order for Lamotrigine, Atorvastatin, and Olanzapine do not match the medication labels. Clarify with physician.</p> <ul style="list-style-type: none"> • Physician’s Order (PO) for Lamotrigine = 25 mg, 3 tabs po qhs. Medication Label (ML) = 25 mg, 1 tab po qhs. • PO for Atorvastatin = 20 mg po qd. ML = 10 mg po qd. • PO for Olanzapine = 5 mg, 2 tabs po qd. ML = 5 mg, 1 tab po qd. 	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><u>FINDINGS</u> Medications made available to Resident #1 not recorded on medication administration record. Last entry was on March 20, 2018. Current date is April 6, 2018. <u>Repeat deficiency from 2017.</u></p>	<p>PART 2 <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>	

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<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><u>FINDINGS</u> Resident #1 – No annual physical examination.</p>	<p>PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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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> (f)(4) General rules regarding records:</p> <p>All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency.</p> <p><u>FINDINGS</u> Resident #1 – Emergency information sheet not up-to-date. Last updated in 2013.</p>	<p>PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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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> (h)(1) Miscellaneous records:</p> <p>A permanent general register shall be maintained to record all admissions and discharges of residents;</p> <p><u>FINDINGS</u> Permanent general register does not reflect two (2) discharged residents. <u>Repeat deficiency from 2017.</u></p>	<p>PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(G) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Smoke detectors shall be provided in accordance with the most current edition of the National Fire Protection Association (NFPA) Standard 101 Life Safety Code, One and Two Family Dwellings. Existing Type I ARCHs may continue to use battery operated individual smoke detector units, however, upon transfer of ownership or primary care giver, such units shall be replaced with an automatic hard wiring UL approved smoke detector system;</p> <p><u>FINDINGS</u> Smoke detector in hallway chirping throughout inspection. Smoke detector was vacuumed but continued to chirp. Must be replaced.</p>	<p>PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (r) Facilities shall be maintained in accordance with provisions of state and local zoning, building, fire safety and health codes.</p> <p><u>FINDINGS</u> No monthly smoke detector check in March 2018. <u>Repeat deficiency from 2017.</u></p>	<p>PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____