

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Pohai Nani 'Ahui Laule'a	CHAPTER 100.1
Address: 45-090 Namoku Street, Kaneohe, Hawaii, 96744	Inspection Date: October 3, 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.**

18 OCT 29 P2:07  
STATE OF HAWAII  
DOH-OSHA  
STATE LICENSING

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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)(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><b><u>FINDINGS</u></b> Substitute care giver (SCG)#1 – No current first aid certification on file.</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;"><i>Provided ARCH a copy of first aid certificate (attached) completion date</i></p>	<p style="text-align: center;"><i>10/3/18</i></p>

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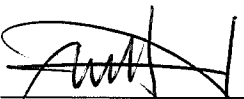
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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4)            The substitute care giver who provides coverage for a period less than four 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><b><u>FINDINGS</u></b>            SCGs #1 to #27 – No documentation that Primary care giver (PCG) trained SCG#1 to #28 to make prescribed medications available to residents.</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>All certified Nursing Assistants (C.N.A.)/ Caregivers assigned to the ARCH at Pohai Nani are trained annually in Medication Administration by Registered Nurse. Certificate of completion (attached) <sup>Revision</sup> indicate that PCG/CHO has participated in required medication administration training.</p>	<p>10/23/18</p> <p style="text-align: right;">18 OCT 29 P 2:07</p> <p style="text-align: right; transform: rotate(-90deg);">STATE OF HI DHF-CHOA STATE LICENSING</p> <p style="text-align: right; transform: rotate(-90deg);">RECEIVED</p>

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STATE OF HAWAII  
 DEPARTMENT OF HEALTH  
 STATE LICENSING

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Licensee's/Administrator's Signature:   
Print Name: Judith E. Matthews BSN DRA/ARH  
Date: 10-24-18

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STATE LICENSING