Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Pohai Nani 'Ahui Malie (E-ARCH)	CHAPTER 100.1
Address: 45-090 Namoku Street, Kaneohe, Hawaii 96744	Inspection Date: October 10, 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.

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. **<u>FINDINGS</u>** No documentation that PCG trained SCG#1 to SCG#28 to make prescribed medication available to residents.	**PART 1** **<u>DID YOU CORRECT THE DEFICIENCY?</u>** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** All certified Nursing Assistant (C.N.As) / Caregivers assigned to the ARCH at Pohai Nani are trained annually in Medication Administration by a Registered Nurse. Certificates of completion (Revision attached) indicate that PCG / CHO has participated in required medication administration training.	10/23/18

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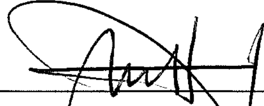
Licensee's/Administrator's Signature: 

Print Name: Judith E. Matthews BSW Dir AL/ARCH

Date: 10-24-18

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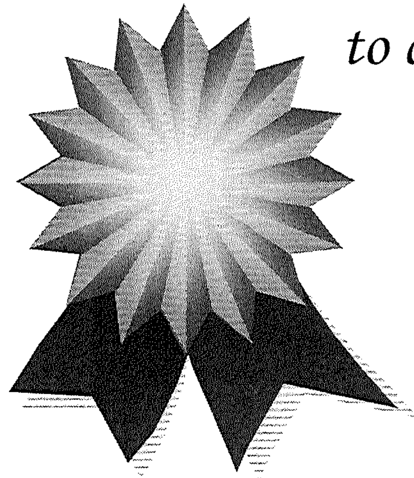
Good Samaritan Pohai Nani
Certificate of Completion

is hereby granted to:



to certify that she has completed 8 hours of

Medication Administration Training

Granted: ____________________

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Judith E. Matthews BSN
Director AL/ARCH

Beatriz Bumanglag RN