

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name: Aloha Nui Care Home LLC</b>	<b>CHAPTER 100.1</b>
<b>Address: 1662 Hookani Street, Pearl City, Hawaii 96782</b>	<b>Inspection Date: February 20, 2019 Initial</b>

**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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19 FEB 14 10 33 AM

	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><b><u>FINDINGS</u></b>  Substitute care giver (SCG) #3 - No physical examination prior to contact with 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 style="text-align: center;">Yes, corrected.  SCG # 3 submitted physical examination to this ARCH.  This ARCH has the record on our file</p>	<p style="text-align: center;">2/28/19</p> <p style="text-align: center;">19 02 17 23:25</p> <p style="text-align: center;">RECEIVED</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>  Substitute care giver (SCG) #3 - No physical examination prior to contact with residents.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><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;"> This ARCH now has physical examinations for all substitute care givers. This ARCH will get employees physical prior to working at this ARCH in the future </p>	<p style="text-align: right;">19 MAR 14 PM 5:55</p> <p style="text-align: right;">RECEIVED</p>

	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><b><u>FINDINGS</u></b> SCG #3 - No tuberculosis clearance prior to contact with 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 style="text-align: center;">SCG #3 submitted Chest x-ray result on 2/28/19. This ARCH has her record in our file</p>	<p style="text-align: center;">2/28/19</p> <p style="text-align: right; font-size: small;">19 109 14 P3:05</p> <p style="text-align: right; font-size: small; transform: rotate(90deg);">RECEIVED</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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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> SCG #1 and #2 - No training 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 style="text-align: center;">Training done on 2/27/19 and completed the training form. All SCG's are now trained in medication administrations.</p>	<p style="text-align: center;">2/27/19</p> <p style="text-align: center;">19 MAR 14 PM 05</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (d) The Type I ARCH shall only admit residents at appropriate levels of care. The capacity of the Type I ARCH shall also be limited by this chapter, chapter 321, HRS, and as determined by the department.</p> <p><b><u>FINDINGS</u></b> Resident #1 - Admitted 1/22/19. Level of care completed 12/27/18 noted that the resident required the following:</p> <ul style="list-style-type: none"> <li>• Total assistance for bathing, dressing/grooming, mobility, toileting, incontinence.</li> <li>• Need for some physical assistance with transfers</li> <li>• Total points for ADL was 17</li> <li>• Level of care assessment was ARCH level</li> </ul> <p>The admission assessment by the primary care giver noted the resident required complete assistance with bathing and dressing.</p> <p>The self-preservation certification dated 12/27/18 noted that the resident is ambulatory and is capable of following directions and taking appropriate action for self-preservation under emergency conditions. On 2/20/19, the resident was wheelchair dependent, required maximum assistance from two (2) care givers to get to standing position from the wheelchair, was able to ambulate approximately 5 feet with physical assistance using the walker, required maximum assistance of one (1) care giver to transfer from the wheelchair to the bed.</p> <p>The home is licensed as an ARCH.</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>Discussed with resident's family and MD <del>to</del> re-assess resident level of care that may not be ARCH level. Resident was brought to MD's office and re-assessed by MD. MD completed the ARCH form that is not ARCH level. Discussed with family regarding safe care and decided to move to expanded LOC Care Home by 3/20/2019. Family signed transfer care form and will transfer out.</p>	<p style="text-align: right;">error MT <del>2/23/19</del></p> <p style="text-align: right;">3/5/19</p> <p style="text-align: right;">19 MAR 14 P 3:55</p> <p style="writing-mode: vertical-rl; text-orientation: mixed;">RECEIVED</p>



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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<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><b>FINDINGS</b> Resident #1 - "levothyroxine" label noted "Take this medication on an empty stomach preferably 1/2 to 1 hour before breakfast." The February 2019 medication record noted the "levothyroxine" is taken at 8 a.m. Breakfast is served at 8 a.m.</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;">changed medication administration time to 7:30 am which is 30 min prior to breakfast</p>	<p style="text-align: right;">env MT 12/9 2/23/19</p> <p style="text-align: right;">19 MAR 14 P 3:35</p> <p style="text-align: right; writing-mode: vertical-rl; transform: rotate(180deg);">RECEIVED</p>

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<input checked="" type="checkbox"/>	<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><b>FINDINGS</b> Resident #1 - "Increase Seroquel to 75 mg po Q HS" and "Continue Seroquel 25 mg po in the morning" ordered 1/28/19; however, the label read: "Take 1 tablet every morning and take 2 tablets in the evening as directed."</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;">MD changed bottle label when resident brought to MD's office. Also MD refilled medication as same as order. Bottle label is now the same as order sheet currently.</p>	<p style="text-align: center;">3/5/19</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver.</p> <p><b><u>FINDINGS</u></b> Resident #1 - "lactulose, dulcolax 10 mg suppository and Miralax powder" were ordered 1/18/19; however, were not recorded on the February 2019 medication record.</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;">Made prn order sheet for february 2019 and put PRN Medication in the sheet.</p>	<p style="text-align: center;">2/23/19</p> <p style="text-align: center;">19 MAR 14 P 3:35</p> <p style="text-align: center;">SIRI LUCAS</p> <p style="text-align: center;">SIRI LUCAS</p> <p style="text-align: center;">REC'D</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)(1) General rules regarding records:</p> <p>All entries in the resident's record shall be written in black ink, or typewritten, shall be legible, dated, and signed by the individual making the entry;</p> <p><b>FINDINGS</b> Resident #1 - Pencil used on the January 2019 medication record. Pencil was also used on the admission medication list to cross out and/or make changes to the medication list.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p style="text-align: center;">.19 MAR 14 P 3:35</p> <p style="text-align: center;">STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES STATE LIBRARIAN</p> <p style="text-align: center;">RECEIVED</p>



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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (f)(1) General rules regarding records:</p> <p>All entries in the resident's record shall be written in black ink, or typewritten, shall be legible, dated, and signed by the individual making the entry;</p> <p><b><u>FINDINGS</u></b> Resident #1 - Pencil used on the January 2019 medication record. Pencil was also used on the admission medication list to cross out and/or make changes to the medication list.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><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;"><i>Won't use pencil to document in the future and will ensure to use either a black pen or type it out, date, and sign all entries.</i></p>	<p style="text-align: right; vertical-align: bottom;">19 MAR 14 P3:35</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-19 <u>Resident accounts.</u> (a)  The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative.</p> <p><b><u>FINDINGS</u></b>  Resident #1 - No signed financial agreement.</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>Family signed financial agreement</i></p>	<p style="text-align: center;"><i>2/23/19</i></p> <p style="text-align: center;">19 MAR 14 P 3:35</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-21 <u>Residents' and primary care givers' rights and responsibilities.</u> (a)(2)(E) Residents' rights and responsibilities:</p> <p>Each resident shall:</p> <p>Be treated with understanding, respect, and full consideration of the resident's dignity and individuality, including privacy in treatment and in care of the resident's personal needs;</p> <p><b>FINDINGS</b> Resident #1 - No written consent from the resident's family for use of surveillance camera in the bedroom.</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>Family signed agreement for use of surveillance camera on 2/23/19</i></p>	<p style="text-align: center;"><i>2/23/19</i></p> <p style="text-align: center;">19 MAR 14 P 3:35</p> <p style="text-align: center;">STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES STATE LICENSING</p> <p style="text-align: right;"><i>RECEIVED</i></p>

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Licensee's/Administrator's Signature: Mhwa

Print Name: Minhye Takamatsu

Date: 3/12/19

Licensee's/Administrator's Signature: Mhwa

Print Name: Minhye Takamatsu

Date: 4/10/19

Licensee's/Administrator's Signature: Mhwa

Print Name: Minhye Takamatsu

Date: 5/23/19