Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Callo Care Home	**CHAPTER 100.1**
Address: **1027 A Lowell Place, Honolulu, Hawaii 96817**	**Inspection Date: January 8, 2020 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) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** Substitute Care Giver (SCG) #2- No evidence of initial tuberculosis clearance available for review.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** SCG #2 had an initial TB clearance on 10/9/03, however, it was inadvertently filed in the old binder. She has already worked here for over 19 years. The only thing that she needs is her annual TB clearance and it was available at the time of the annual inspection. The initial TB clearance is already filed in the binder. 1/10/20	1/10/20

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☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** SCG #2- No evidence of initial tuberculosis clearance available for review.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To prevent this from happening again in the future, we will place a reminder note in the logbook or on the refrigerator door that the initial TB clearance needs to be shown for annual review.	1/10/20

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-81 Minimum structural requirements. (b) All signaling devices shall be approved by the department and installed at bedside, in bathrooms, toilet rooms, and other areas where expanded ARCH residents may be left alone. All such signaling devices shall be approved by the department. In expanded ARCHs where the primary care giver and expanded ARCH residents do not reside on the same floor or when other signaling mechanisms are deemed inadequate, electronic signaling systems shall be installed. **FINDINGS** Resident #2 – No signaling device at bedside.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Resident #2 has a signaling device, however the resident accidentally put it in her drawer when she organized her nightstand. The signaling device is already on the resident's bedside. 1/8/20	1/8/20

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-81 Minimum structural requirements. (b) All signaling devices shall be approved by the department and installed at bedside, in bathrooms, toilet rooms, and other areas where expanded ARCH residents may be left alone. All such signaling devices shall be approved by the department. In expanded ARCHs where the primary care giver and expanded ARCH residents do not reside on the same floor or when other signaling mechanisms are deemed inadequate, electronic signaling systems shall be installed. **FINDINGS** Resident #2 – No signaling device at bedside.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To prevent this from happening again in the future, I will need to check on a regular basis to make sure that all the residents' signaling devices are where they need to be all the time. If anyone of them is missing, I will make sure to place a note on the door to the patient's room or place a note on the refrigerator door then endorse it to my SCG that the resident needs a signaling device by her bedside. I will also make a reminder note to check the signaling device as often as possible or every day.	1/8/20

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-83 Personnel and staffing requirements. (5) In addition to the requirements in subchapter 2 and 3: Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents. **FINDINGS** SCG #1: No documented evidence of twelve (12) hours of continuing education.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** SCG #1 has already completed her 12 hours continuing education, however, her supervisor has not signed her in-service training yet, she brought it back to her for it to be signed. It is already filed in the binder. 1/13/20	1/13/20

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-83 Personnel and staffing requirements. (5) In addition to the requirements in subchapter 2 and 3: Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents. **FINDINGS** SCG #1: No documented evidence of twelve (12) hours of continuing education.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To prevent this mistake from happening again in the future, I need to make sure that all SCG's and the PCG complete their continuing education requirements earlier than past years, so that there is ample time to get everything done in a timely manner way before the inspection is done. Also, a reminder note will be posted on the refrigerator 2 months prior to the required completion date.	11/30/20

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-88 Case management qualifications and services. (c)(8) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Have face-to-face contacts with the expanded ARCH resident at least once every thirty days, with more frequent contacts based on the resident's needs and the care giver's capabilities; **FINDINGS** Resident #1: No documented evidence that case manager met with resident face-to-face for the months of October, November, and December of 2019.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** According to my SCG, the Case Manager came and met face to face with Resident #1 for the past 3 months, however, she did not provide us with the documentation in the resident's chart. The Case Manager's 3 months visit of the resident are already filed in the binder. 1/15/20	1/15/20

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Licensee's/Administrator's Signature: Callo

Print Name: TESSIE A. CALLO

Date: 2/27/20