

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Galario's Care Home	CHAPTER 100.1
Address: 94-929 Kuakahi Street, Waiphu, Hawaii 96797	Inspection Date: June 17, 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) 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>§11-100.1-23 <u>Physical environment.</u> (g)(3)(I)(i) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either:</p> <p>For each such non-certified resident there must be a responsible adult on the premises of the home at all times that the non-certified resident is present in the home, and there must never be a stairway which must be negotiated for emergency exit by such non-certified resident;</p> <p><u>FINDINGS</u> Resident #1, self-preservation certificate is inconsistent with current resident capacity. On admission (6/27/16), resident was certified as self-preserving. Currently, resident is unable to ambulate with a front wheel walker without 1:1 assistance.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>I took the resident to see MD, certified as N&P using to clearly state N&P Prior MD notes on 6/20/20 resid needs assistance</i></p>	<p style="text-align: center;"><i>7/9/20</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(I)(i) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either:</p> <p>For each such non-certified resident there must be a responsible adult on the premises of the home at all times that the non-certified resident is present in the home, and there must never be a stairway which must be negotiated for emergency exit by such non-certified resident;</p> <p><u>FINDINGS</u> Resident #1, self-preservation certificate is inconsistent with current resident capacity. On admission (6/27/16), resident was certified as self-preserving. Currently, resident is unable to ambulate with a front wheel walker without 1:1 assistance.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>Should a resident's ability to ambulate and/or self preserve a change a form will be submitted to PCP for review, completion return at doctor's visit</i></p> <p><i>In the future a self preservation statement shall be placed in clients file prior to PCP appointment.</i></p>	<p style="text-align: right;"><i>7/14/20</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-84 Admission requirements. (a) Licensees of an expanded ARCH shall admit nursing facility level residents as determined and certified by the resident's physician or APRN.</p> <p>FINDINGS ARCH on 2-1-18 SCB Resident #1, no level of care re-assessment since 6/26/16. Upon admission (6/27/16) level of care assessed as ARCH. However, resident orders include a pureed diet with honey thick liquid, care in all areas of ADL and nebulizer treatments as needed.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>I made an appointment for the MD to examine the resident on 7/11/20. MD changed the LOC to ICF.</i></p> <p><i>I notify the family. They arranged for a case manager to do the initial assessment</i></p>	<p style="text-align: right;"><i>7/14/20</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-84 Admission requirements. (a) Licensees of an expanded ARCH shall admit nursing facility level residents as determined and certified by the resident's physician or APRN.</p> <p>FINDINGS ARCH ON 2-1-18 Resident #1, no level of care re-assessment since 6/26/16. Upon admission (6/27/16) level of care assessed as ARCH. However, resident orders include a pureed diet with honey thick liquid, care in all areas of ADL and nebulizer treatments as needed.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>Primary care giver will put a Level of care form in client file as a reminder. PCC to bring LOC form to the MD for LOC reassessment at the annual physical examination</i></p>	<p style="text-align: right;"><i>7-14-20</i></p>

Licensee's/Administrator's Signature: Elena A. Galario

Print Name: ELENA A. GALARIO

Date: 7/14/20