

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Magsanide's Care Home, L.L.C.	CHAPTER 100.1
Address: 1439 Middle Street, Honolulu, Hawaii 96819	Inspection Date: April 6, 2021 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.

STATE OF HAWAII
DOH-0HCA
STATE LICENSING

21 APR 19 4:43

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	<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>FINDINGS SCG #1,2 – Initial TB clearance unavailable for review. Submit a copy with plan of correction.</p> <p>STATE OF HAWAII DOH-0HCA STATE LICENSING</p> <p>21 APR 19 07:43</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>The next time I hire a SCG, I will always refer to the checklist on chapter 11-100 + 11-101 for all the requirements</p>	<p>4-8-21</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (a) Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be obtained prior to a resident's admission to a Type I ARCH and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's responsible placement agency, and others authorized by the resident to review it.</p> <p>FINDINGS Residents #1,2,3 – Documentation of level of care determined by the resident's physician unavailable for review. Submit a copy with plan of correction.</p> <p style="text-align: right;">STATE OF HAWAII DOH-OHCA STATE LICENSING</p> <p style="text-align: right;">21 APR 19 A7:43</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u> <i>YES</i></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>Made a phone call "telehealth" with the MA & verified each resident's level of care.</i></p>	<p style="text-align: center;"><i>4-7-21</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> <p>§11-100.1-10 <u>Admission policies.</u> (a) Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be obtained prior to a resident's admission to a Type I ARCH and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's responsible placement agency, and others authorized by the resident to review it.</p> <p><u>FINDINGS</u> Residents #1,2,3 – Documentation of level of care determined by the resident's physician unavailable for review. Submit a copy with plan of correction.</p> <p>STATE OF HAWAII DOH-OHCA STATE LICENSING</p> <p>APR 19 12 43</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>Always refer to the admission checklist, double check to make sure the forms are completed properly. I also do go back and look at my previous citations.</p>	<p style="text-align: right;">4-7-21</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> <p>§11-100.1-13 <u>Nutrition.</u> (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit.</p> <p><u>FINDINGS</u> Resident #1 – Current diet order signed by physician unavailable for review. Submit a copy with plan of correction.</p> <p style="text-align: center;">STATE OF HAWAII DOH-OHCA STATE LICENSING</p> <p style="text-align: center;">21 APR 19 17:43</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;">YES</p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;">Took resident to Sec her PCP</p>	<p style="text-align: center;">4-14-21</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit.</p> <p><u>FINDINGS</u> Resident #1 – Current diet order signed by physician unavailable for review. Submit a copy with plan of correction.</p> <p>STATE OF HAWAII DOH-DHCA STATE LICENSING</p> <p>21 APR 19 07:43</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>always refer to checklist on Chapter 11-100 within their anniversary date. Anniversary date is written on my planner.</p>	<p>4-14-21</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; <u>FINDINGS</u> Resident #1 – Annual physical unavailable for review. Submit a copy with plan of correction.	<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;"><i>Yes</i></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>Took resident to see her PCP.</i></p>	<p style="text-align: center;"><i>4-14-21</i></p>

STATE OF HAWAII
DOH-0HCA
STATE LICENSING

21 APR 19 17:44

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><u>FINDINGS</u> Resident #1 – Annual physical unavailable for review. Submit a copy with plan of correction.</p> <p style="text-align: right;">STATE OF HAWAII DOH-CHCA STATE LICENSING</p> <p style="text-align: right;">21 APR 19 07:44</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>Always refer to checklist on chapter 11-100 within their anniversary date. Each resident's anniversary date is written on my planner. Due dates of annual PE & Diet written on my planner.</p>	<p style="text-align: center;">4-14-21</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (o)(2)(B) Bedrooms:</p> <p>Floor space:</p> <p>Beds shall be placed at least three feet apart in multiple occupant bedrooms;</p> <p><u>FINDINGS</u> Bedroom #1 – The two beds located in the bedroom were almost side by side, less than 3 feet apart</p> <p style="text-align: right;">STATE OF HAWAII DOH-OHCA STATE LICENSING</p> <p style="text-align: right;">21 APR 19 07:44</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>With every admission that I'll be getting I will review my chapter 11-100 regarding physical environment. I will ensure to measure the space. I will explain to family members that its safer for resident to have at least 3ft to move around.</p>	<p style="text-align: center;">4-7-21</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (o)(3)(B) Bedrooms:</p> <p>Bedroom furnishings:</p> <p>Each bed shall be supplied with a comfortable mattress cover, a pillow, pliable plastic pillow protector, pillow case, and an upper and lower sheet. A sheet blanket may be substituted for the top sheet when requested by the resident;</p> <p><u>FINDINGS</u> Bedroom #1,2 – Residents' pillows did not have a plastic pillow protector or initials written on the pillow</p> <p>STATE OF HAWAII DOH-ONCA STATE LICENSING</p> <p>21 APR 19 07:44</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u> <i>Yes</i></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Each resident's initial was placed on each pillows.</i></p>	<p>4.7.21</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (o)(3)(B) Bedrooms:</p> <p>Bedroom furnishings:</p> <p>Each bed shall be supplied with a comfortable mattress cover, a pillow, pliable plastic pillow protector, pillow case, and an upper and lower sheet. A sheet blanket may be substituted for the top sheet when requested by the resident;</p> <p><u>FINDINGS</u> Bedroom #1,2 – Residents' pillows did not have a plastic pillow protector or initials written on the pillow</p> <p>STATE OF HAWAII DOH-DHCA STATE LICENSING</p> <p>21 APR 19 07:44</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>again, I will review/refer to the chapter 11-100 checklist with every admission. I will check the pillows every last day of the month to ensure their initial still intact on each pillows.</p>	<p>4.7.21</p>

Licensee's/Administrator's Signature: Editha Maganide

Print Name: EDITHA MAGSANIDE

Date: 4-16-2021

STATE OF HAWAII
OOH-OHCA
STATE LICENSING
21 APR 19 17:44