

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Oililua Elder Care, Inc #I	CHAPTER 100.1
Address: 94-379 Oililua Place, Waipahu, Hawaii 96797	Inspection Date: October 22, 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) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

STATE OF HAWAII
DOH-CHC
STATE LICENSE

21 NOV -8 P1:44

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p><u>FINDINGS</u> SCG #1 – No documented evidence of current first aid certification.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Deficiency was corrected. Copy of current first aid certificate for SCG #1 was obtained from the provider and placed in the carehome binder available for inspection.</p>	10/24/21

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p><u>FINDINGS</u> SCG #1 – No documented evidence of current first aid certification.</p> <p>STATE OF HAWAII DOH-0907 STATE LICENSE NO.</p> <p>21 NOV -8 P1:44</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>To prevent similar deficiency in the future, I will check myself and my substitute caregiver my daily checklist , put it in my calendar reminder.</p>	10/24/21

RULES (CRITERIA)	PLAN OF CORRECTION	
	PART 1	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall: Be currently certified in cardiopulmonary resuscitation; <u>FINDINGS</u> SCG #1 – No documented evidence of current cardiopulmonary certification.	<p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Deficiency was corrected. Copy of current cardiopulmonary certification for SCG#1 was obtained from the provider and placed it in the carehome binder available for inspection.</p>	10/24/21

STATE OF HAWAII
 DEPT. OF HEALTH
 STATE LICENSES

21 NOV -8 P1:44

	RULES (CRITERIA)	PLAN OF CORRECTION	
			Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:</p> <p>Be currently certified in cardiopulmonary resuscitation;</p> <p><u>FINDINGS</u> SCG #1 – No documented evidence of current cardiopulmonary certification.</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>To prevent similar deficiency in the future, I will always check my daily calendar reminder checklist. My substitute caregiver is assigned to double check the reminder checklist for accuracy.</p>	<p>10/24/21</p>

STATE OF MAINE
DOH-0004
STATE LIBRARY

21 NOV -8 P1:44

	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><u>FINDINGS</u> Resident #1 – Signed medication orders on 3/24/2021 and 8/27/2021 do not include dosages for all medications.</p> <p>STATE OF HAWAII DOH-CD-2 STATE LICENSE NO.</p> <p>21 NOV -8 P1:44</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Deficiency was corrected. MD was contacted and correction was made that includes dosages of all medications currently administered on 3/24/21 and 8/27/21 for Resident #1. Correction made by physician was placed in Resident #1 folder available for inspection.</p>	11/1/21

	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><u>FINDINGS</u> Resident #1 – Signed medication orders on 3/24/2021 and 8/27/2021 do not include dosages for all medications.</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>See Attached</p>	<p>22 JAN 10 P4:01</p> <p>STATE OF HAWAII DH-CHCA STATE LICENSE</p>

OILILUA ELDERCARE, INC.

94-379 OILILUA PLACE

WAIPAHU, HAWAII

96734

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AFTER VISIT SUMMARY BY PHYSICIAN/APRN

-CHECK FOR COMPLETE MEDICATION ORDER:NAME OF MEDICATION,
STRENGTH, DOSAGE,ROUTE.

Termonie

January 9, 2022

'22 JAN 10 P4:02

STATE OF HAWAII
DOH-ORCA
STATE LICENSING

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year.</p> <p>FINDINGS Resident #1 – Medications not reevaluated and signed every 4 months from 3/24/2021 to 8/27/2021.</p> <p>STATE OF HAWAII DOH-SDA STATE LICENSES</p> <p>21 NOV -8 P 1:44</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year.</p> <p><u>FINDINGS</u> Resident #1 – Medications not reevaluated and signed every 4 months from 3/24/2021 to 8/27/2021.</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>See Attached</p>	<p>22 JAN 10 P 4:02</p> <p>STATE OF HAWAII DEPARTMENT OF STATE LICENSING</p>

OILILUA ELDERCARE, INC.

94-379 OILILUA PLACE

WAIPAHU, HAWAII

96734

'22 JAN 10 P 4:02

STATE OF HAWAII
DOH-ORCA
STATE LICENSING

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MONTHLY CHECKLISTS:

UPDATE/RENEW THE FOLLOWING IF NEEDED FOR STAFF/RESIDENTS

PHYSICAL EXAM

TB ATTESTATION IF APPLICABLE

TB TESTS

MONTHLY SUMMARY DOCUMENTATION OF RESIDENTS PROGRESS NOTES

MEDICATION REVIEW AND SIGNED BY PHYSICIAN EVERY 4 MONTHS

STAFF

CHECK FOR CPR/FIRST AID

12 HOUR CONTINUING EDUCATION

PHYSICAL EXAM

Remond

January 9, 2022

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-86 <u>Fire safety.</u> (a)(3) A Type I expanded ARCH shall be in compliance with existing fire safety standards for a Type I ARCH, as provided in section 11-100.1-23(b), and the following:</p> <p>Fire drills shall be conducted and documented at least monthly under varied conditions and times of day;</p> <p><u>FINDINGS</u> No documented fire drill for September 2021.</p> <p>STATE OF HAWAII DOH-SDCA STATE LIDENBAND</p> <p>21 NOV-8 P1:44</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Deficiency was corrected. Fire drill was conducted and placed on file.</p>	10/23/24

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-86 <u>Fire safety.</u> (a)(3) A Type I expanded ARCH shall be in compliance with existing fire safety standards for a Type I ARCH, as provided in section 11-100.1-23(b), and the following:</p> <p>Fire drills shall be conducted and documented at least monthly under varied conditions and times of day;</p> <p><u>FINDINGS</u> No documented fire drill for September 2021.</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>To prevent the same deficiency in the future, FIRE DRILL was added into my monthly checklist and written down on my calendar for reminder.</p>	10/23/21

STATE OF HAWAII
DOH-CHS
STATE LIBRARIAN
21 NOV -8 P1:44

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(10) 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:</p> <p>Conduct comprehensive reassessments of the expanded ARCH resident every six months or sooner as appropriate;</p> <p><u>FINDINGS</u> Resident #1 – Comprehensive reassessment of the expanded resident not completed every 6 months, but yearly.</p> <p>STATE OF HAWAII DON-0904 STATE LICENSE NO</p> <p>21 NOV -8 P1:44</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(10) 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:</p> <p>Conduct comprehensive reassessments of the expanded ARCH resident every six months or sooner as appropriate;</p> <p><u>FINDINGS</u> Resident #1 – Comprehensive reassessment of the expanded resident not completed every 6 months, but yearly.</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>See Attached</p>	<p>22 JAN 10 PM 4:02</p> <p>STATE OF HAWAII DEPT. OF HEALTH STATE LICENSING</p>

OILILUA ELDERCARE, INC

94-379 OILILUA PLACE

WAIPAHU, HAWAII

'22 JAN 10 P4:02

STATE OF HAWAII
DOH-DHCA
STATE LICENSING

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96734

RN CASE MANAGER CHECKLISTS:

- COMPLETE COMPREHENSIVE ASSESSMENT UPON ADMISSION OF EXPANDED ARCH RESIDENT.
- COMPLETE CARE PLAN UPON ADMISSION OR READMISSION OF EXPANDED ARCH RESIDENT
- MONTHLY FACE TO FACE VISIT
- NOTIFY RN CM FOR ANY CHANGE OF STATUS OF RESIDENT
- COMPLETE EVERY 6 MONTHS COMPREHENSIVE REASSESSMENT OF THE EXPANDED RESIDENT

- *Terrie*

January 9, 2022

Licensee's/Administrator's Signature: Gerónimo

Print Name: GERONIMO TENORIO

Date: 11/05/2021

STATE OF HAWAII
DOH - OPCA
STATE LICENSING
21 NOV -8 P1:44

Licensee's/Administrator's Signature: Gerónimo

Print Name: GERONIMO TENORIO

Date: DECEMBER 15, 2021

Resubmitted: January 9, 2022

STATE OF HAWAII
BOH-0101
STATE LICENSING

22 JAN 10 P 4:02