

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Hale Lihiko	CHAPTER 100.1
Address: 1033 Ala Lihiko Street, Honolulu, Hawaii 96818	Inspection Date: August 5, 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
DOROTHY
STATE LICENSING

21 AUG 19 AM 1:32

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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) #1 - No current tuberculosis clearance. Submit a copy with your plan of correction (POC).	<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 style="text-align: center;">Sylvia Cho is not available at this time. For my substitute she needs to take care of her mom and step dad at home. I have a new substitute.</p>	<p style="text-align: center;">8/18/2021</p>

STATE OF HAWAII
 DON-DMCA
 STATE LICENSING

21 AUG 19 AM 11:32

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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. <u>FINDINGS</u> Substitute care giver (SCG) #1 - No current tuberculosis clearance. Submit a copy with your plan of correction (POC).	<p style="text-align: center;">PART 2 <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 will use clearance spread sheet for all new caregivers to keep track of the clearance expiration. I will check the date of actual clearance or screening date. In stead of looking out the date of the letter.</p>	<p style="text-align: center;">12/21/21</p>

DEPARTMENT OF CORRECTIONS
STATE OF HAWAII

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-15 Medications: (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. <u>FINDINGS</u> Resident #1 - "Acetaminophen (Tylenol) Take 1 tab by mouth every 4 hours as needed for pain" ordered 7/10/21; however, the medication record noted "every 6 hours."	<p style="text-align: center;">PART I</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>Resident's PCP stopped Tylenol 500mg. 1tab by mouth every 4 hours and start Tylenol 500mg 1tab by mouth as needed for pain or fever every 6 hours. I received the new order on 8/18/21</p>	<p style="text-align: right;">8/18/21</p> <p style="text-align: right;">AUG 19 AM 11:32</p> <p style="text-align: right;">STATE OF HAWAII DOH-ORCA STATE LICENSING</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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. FINDINGS Resident #1 - "Acetaminophen (Tylenol) Take 1 tab by mouth every 4 hours as needed for pain" ordered 7/10/21; however, the medication record noted "every 6 hours."	<p style="text-align: center;">PART 2 <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>At the time of readmit, I will check the discharge medication orders I will record the medication on a ^{SP} new MAR. MAR.</p> <p>A new medication record ^{error} ^{SP}, I will check the medication label and compare with the discharge medication orders if there is a discrepancy, I will clarify the medication order and label with PCP.</p>	<p style="text-align: right;">10/21/21</p>

NATIONAL BOARD OF EXAMINERS
 STATE OF HAWAII
 BOARD OF PHARMACY
 STATE LICENSING

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 Records and reports. (a)(6) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Physician or APRN signed orders for diet, medications, and treatments; <u>FINDINGS</u> Resident #1 - No physician order for "Ensure 240 ml daily" recorded on the medication record and taken by the resident.	<p style="text-align: center;">PART I</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 style="text-align: center;">I obtained resident's PCP's original order, Ensure plus 240ml by mouth once daily on 8/11/21 AS of 7/10/2021</p>	<p style="text-align: center;">8/16/2021</p> <p style="text-align: center;">AUG 19 AM 11:33</p> <p style="text-align: center;">STATE OF HAWAII BOH-CHCA STATE LICENSING</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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ENGINEERING STATE
 BOARD
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 STATE OF ILLINOIS

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 Records and reports. (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; FINDINGS Progress notes did not include observations of the resident's post pacemaker insertion site dressing, dressing changes, compliance with reminders not to lift her arm and sling that she used for two (2) days.	<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;">After discharge, I will observe changes in the resident's physical appearance including bandage changes. Sling is on and off date. I will enter all the observations in the progress notes.</p>	<p style="text-align: center;">8/16/2024</p> <p style="text-align: center;">21 AUG 19 AM 1:33</p> <p style="text-align: center;">STATE OF HAWAII DOH-DHCA STATE LICENSING</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-23 Physical environment. (p)(5) Miscellaneous: Signaling devices approved by the department shall be provided for resident's use at the bedside, in bathrooms, toilet rooms, and other areas where residents may be left alone. In Type I ARCHs where the primary care giver and residents do not reside on the same level or when other signaling mechanisms are deemed inadequate, there shall be an electronic signaling system. FINDINGS No bathroom signaling devices.	<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 style="text-align: center;">PART 1</p> <p style="text-align: center;"><i>I place and hang the bells in each bathroom.</i></p>	<p style="text-align: center;"><i>8/18/2021</i></p> <p style="text-align: center;">21 AUG 19 AM 11:33 STATE OF HAWAII DEPT. OF HEALTH STATE LICENSING</p>

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STATE OF MARYLAND
DGN-OMCA
STATE LICENSING

AUG 19 21 33

Licensee's/Administrator's Signature:

J Phillips

Print Name:

Soo Phillips

Date:

9/18/2021

Licensee's/Administrator's Signature:

J Phillips

Print Name:

Soo Yeon Phillips

Date:

9/29/2021

Licensee's/Administrator's Signature:

J Phillips

Print Name:

Soo Yeon Phillips

Date:

10/21/2021