Office of Health Care Assurance

**State Licensing Section**

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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| **Facility's Name: Kailua Ohana** | **CHAPTER 100.1** |
| **Address: 1346 Akamai Street, Kailua, Hawaii 96734** | **Inspection Date: July 12, 2022 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 |
|---|---|---|---|
| ☒ | §11-100.1-3 Licensing. (b)(1)(I) Application.<br><br>In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application:<br><br>Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law;<br><br>**FINDINGS**<br>Primary Care Giver (PCG), Substitute Care Giver (SCG) & Household Member (HM) – No current documented evidence stating aforementioned care givers have no prior felony or abuse convictions in a court of law.<br><br>**Please submit a copy of field print results as evidence of completion.**<br><br>STATE LICENSING<br>DOH-OHCA<br>STATE OF HAWAII<br><br>22 AUG -5 P4:01 | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>Criminal clearance for PCG, SCG and HM were completed last week, July 20. The results will be sending to us in about two weeks.<br><br>Attached copies of field print schedules for PCG, SCG and HM as evidence of completion. I will be submitting copies of the results to the department as soon I received them. | 7/26/22 |

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| ☒ | §11-100.1-13 Nutrition. (l)<br>Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets.<br><br>**FINDINGS**<br>Resident #1 – Physician order for diet dated 6/29/22 for "Regular, moist mechanical soft ¼ inch. Thin fluids"; however no special diet menu observed in facility. | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>On July 13, I reported by phone to APRN about the resident's chewing and swallowing had improved. But, the resident was still on special diet. I requested APRN to consider adjusting the resident's diet based on my assessment. APRN ordered Regular soft diet. | 7/26/22 submitted<br><br>8/5/22 (revised)<br>Edna Lomeda |

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| ☒ | §11-100.1-17 Records and reports. (b)(3)<br>During residence, records shall include:<br><br>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;<br><br>**FINDINGS**<br>Resident #1 – No progress notes indicating if restraint usage is helping/not helping resident. | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>On July 12, I charted on the patient's progress notes as a late entry on why patient was on the wheelchair seatbelt. And, I documented the indication that seatbelt usage was helping the resident. | 7/26/22 |

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| ☒ | §11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(2)(C)<br>Residents' rights and responsibilities:<br><br>Each resident shall:<br><br>Be free from chemical and physical restraints and not be humiliated, harassed, or threatened.<br><br>**FINDINGS**<br>Resident #1 - Observed resident with seatbelt restraint. No documented evidence of a physician or advanced practice registered nurse (APRN) order for restraint use, purpose of restraint, frequency of restraint usage, duration of restraint usage, and alternative care that can be provided to the restraint.<br><br>'22 JUL 26 P4:08<br>STATE OF HAWAII<br>SCH-CHCA<br>STATE LICENSING | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>Since I found out that wheelchair seatbelt is considered a restraint, I decided to change to magnetic pull cord alarm. I reported to APRN on June 13. APRN ordered to discontinue the wheelchair seatbelt. On July 20, APRN came over to the care home to evaluate on the resident condition. Also, I have an extra help from my caregiver to focus more on this resident to prevent him from falling. | 7/26/22 |

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| ☒ | §11-100.1-87 Personal care services. (a)<br>The primary care giver shall provide daily personal care and specialized care to an expanded ARCH resident as indicated in the care plan. The care plan shall be developed as stipulated in section 11-100.1-2 and updated as changes occur in the expanded ARCH resident's care needs and required services or interventions.<br><br>**FINDINGS**<br>Resident #1 - Care plan dated 6/29/22, titled "Alteration in skin integrity" listed the following intervention: "When in bed change position every 2 hours, as needed"; however no documented evidence of repositioning. | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>On July 12, I did a late entry to the resident's flowsheet to those days that the resident needed assistant with turning. Then, I updated when the resident was able to turn/move himself. Also, notified the case manager to update the resident care plan on her next visit. | 7/26/22 |

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Licensee's/Administrator's Signature: [signature]

Print Name: EDNA LOWNDES

Date: 7/26/22

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