

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Yoon's Care Home	CHAPTER 100.1
Address: 1754 Komo Mai Drive, Pearl City, Hawaii 96782	Inspection Date: May 18, 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) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

22
MAY-1 AM 36
STATE OF HAWAII
OFFICE OF HEALTH CARE ASSURANCE
STATE LICENSING

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>. (b)(1)(I) Application.</p> <p>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:</p> <p>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;</p> <p><u>FINDINGS</u> Primary caregiver (PCG), Substitute Caregiver (SCG) #1-3 – FieldPrint clearances unavailable for review</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 style="text-align: center;">fingerprint was cleared on 5/19/22.</p> <p style="text-align: right;">STATE OF HAWAII DOH-CHCA STATE LICENSING</p>	<p style="text-align: right;">5/19/22</p> <p style="text-align: right;">22 JUN 17 P12:10</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>. (b)(1)(I) Application.</p> <p>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:</p> <p>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;</p> <p><u>FINDINGS</u> Primary caregiver (PCG), Substitute Caregiver (SCG) #1-3 – FieldPrint clearances unavailable for review</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>care home operator will put fieldprint clearance in new hire checklist and employee annual calendar every January and place in front of working desk</p>	<p>6/8/22</p> <p>22 AUG -1 AM 1:36</p> <p>STATE OF NEW YORK DEPARTMENT OF SOCIAL SERVICES STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<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 #2 – Initial 2-step TB clearance unavailable for review. Submit a copy with plan of correction.</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>Carehome operator verified with SCG #2 and SCG 2 did TB test on 5/23 which was positive, so did x-ray on 5/25 which was negative.</p> <p>TB clearance was filled up by MD on 6/14/22</p>	<p>6/14/22 AUG -1 AM 1:36</p> <p>STATE OF CONNECTICUT DEPT. OF SOCIAL SERVICES STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<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><u>FINDINGS</u> SCG #2 – Initial 2-step TB clearance unavailable for review. Submit a copy with plan of correction.</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>Care home operator will make new hire checklist & annual employee checklist and put 2 step PPD or x-ray will post it in front of working desk</p>	<p>22 6/10/22 11:36 STATE OF MICHIGAN DEPT. OF HEALTH LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><u>FINDINGS</u> SCG #1 – Primary caregiver (PCG) training unavailable for review. Submit a copy with plan of correction.</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>Actubally SCG #1 got training by PCG but just forgot to document.</p> <p>STATE OF HAWAII DOH-DHCA STATE LICENSING</p>	<p>1/30/22 ✓ 3/31/22 ✓</p> <p>22 JUN 17 PM 2:10</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><u>FINDINGS</u> SCG #1 – Primary caregiver (PCG) training unavailable for review. Submit a copy with plan of correction.</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>primary caregiver training on medication added it to new hire checklist. to be used for all new caregiver,</p>	<p>6/10/22</p> <p>22 AUG -1 11:36</p> <p>STATE OF HAWAII DEPARTMENT OF HEALTH STATE RECORDING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (d) Current menus shall be posted in the kitchen and in a conspicuous place in the dining area for the residents and department to review.</p> <p>FINDINGS Resident #1 – Special diet menu provided for pureed diet is not appropriate for the prescribed diet. Submit a copy of revised diet with plan of correction.</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>Carehome operator discussed with OHCA nutritionist about special diet (pureed diet). OHCA nutritionist sent new version of menu and CHO made new menu as follow special diet rule from OHCA on 6/5/22 then posted it in the refrigerator dining area.</p>	<p>6/5/22</p> <p>22 AUG -1 AM 1:36</p> <p>STATE OF HAWAII DEPARTMENT OF SCIENCE & TECHNOLOGY</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (d) Current menus shall be posted in the kitchen and in a conspicuous place in the dining area for the residents and department to review.</p> <p><u>FINDINGS</u> Resident #1 – Special diet menu provided for pureed diet is not appropriate for the prescribed diet. Submit a copy of revised diet with plan of correction.</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>care home operator will post OHCA nutritionist information next to menu in refrigerator and will contact them if have any question about special diet.</p>	<p>6/9/22</p> <p>STATE OF HAWAII DEPT. OF HEALTH STATE LICENSES</p> <p>22 AUG -1 AM 1:36</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (d) Current menus shall be posted in the kitchen and in a conspicuous place in the dining area for the residents and department to review.</p> <p><u>FINDINGS</u> Resident #2 – Diet order dated, 9/7/21, states “chopped texture”; however, menu for chopped diet unavailable for review. Submit a copy of chopped diet menu with plan of correction.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p><u>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</u></p> <p>Care home operator contacted OHCA nutritionist about chopped diet and corrected the deficiency and made new menu. and post posted it in dining area.</p>	<p>6/9/22 ✓</p> <p>22 AUG -1 AM 1:36</p> <p>STATE OF HAWAII DEPT. OF HEALTH STATE LICHENING</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (d) Current menus shall be posted in the kitchen and in a conspicuous place in the dining area for the residents and department to review.</p> <p><u>FINDINGS</u> Resident #2 – Diet order dated, 9/7/21, states “chopped texture”; however, menu for chopped diet unavailable for review. Submit a copy of chopped diet menu with plan of correction.</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>Carehome operator posted OHCA nutritionist information next to menu in refrigerator and will contact them if ^{have} any question</p>	<p>22 AUG -1 AM 1:36</p> <p>STATE OF HAWAII DEPARTMENT OF HEALTH STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-19 <u>Resident accounts.</u> (d) An accurate written accounting of resident's money and disbursements shall be kept on an ongoing basis, including <u>receipts for expenditures, and a current inventory of resident's possessions.</u></p> <p>FINDINGS Resident #1 – No documented evidence annual inventory was performed on resident's possessions. Submit a copy with plan of correction.</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>Annual inventory of resident's possessions was performed on 8/1/22</p>	<p>8/1/22</p>

STATE OF ILLINOIS
 DEPARTMENT OF
 STATE LICENSING

22 AUG -1 AM 1:36

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<input checked="" type="checkbox"/>	<p>§11-100.1-19 <u>Resident accounts.</u> (d) An accurate written accounting of resident's money and disbursements shall be kept on an ongoing basis, including receipts for expenditures, and a current inventory of resident's possessions.</p> <p><u>FINDINGS</u> Resident #1 – No documented evidence annual inventory was performed on resident's possessions. Submit a copy with plan of correction.</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>Care home operator will put annual resident's possession inventory in front of resident's chart.</p> <p>Reminder note in front of resident's chart.</p>	<p>8/1/21</p> <p style="text-align: right;">22 AUG -1 AM 1:36</p> <p style="text-align: right; transform: rotate(-90deg);">STATE OF NEW YORK NOTES STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-21 <u>Residents' and primary care givers' rights and responsibilities.</u> (a)(2)(E) Residents' rights and responsibilities:</p> <p>Each resident shall:</p> <p>Be treated with understanding, respect, and full consideration of the resident's dignity and individuality, including privacy in treatment and in care of the resident's personal needs;</p> <p><u>FINDINGS</u> Resident #3,4 – Video surveillance cameras installed in bedrooms; however, no signed consents available. Submit a copy of signed consents with plan of correction.</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>The carehome operator initiated and presented to the residents power of attorney a "consent to use surveillance camera."</p> <p>POA agreed and consent form was signed by POA.</p>	<p>6/9/22</p> <p>STATE OF MAINE DEPT. OF STATE POLICE</p> <p>22 AUG -1 AM 1:36</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-21 <u>Residents' and primary care givers' rights and responsibilities.</u> (a)(2)(E) Residents' rights and responsibilities:</p> <p>Each resident shall:</p> <p>Be treated with understanding, respect, and full consideration of the resident's dignity and individuality, including privacy in treatment and in care of the resident's personal needs;</p> <p><u>FINDINGS</u> Resident #3,4 – Video surveillance cameras installed in bedrooms; however, no signed consents available. Submit a copy of signed consents with plan of correction.</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>Will add on Consent form in resident's record folder so and admission pocket as well. 6/14/22</p> <p>STATE OF HAWAII DOH-CHCA STATE LICENSING</p>	<p>22 JUN 17 PM 2:09</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(D) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>A drill shall be held to provide training for residents and personnel at various times of the day or night at least four times a year and at least three months from the previous drill, and the record shall contain the date, hour, personnel participating and description of drill, and the time taken to safely evacuate residents from the building. A copy of the fire drill procedure and results shall be submitted to the fire inspector or department upon request;</p> <p><u>FINDINGS</u> Duration of fire drill performed in 10/2021 was not documented</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>	

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	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> Performance of monthly fire drill for 4/2022 unavailable for review</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>§11-100.1-86 <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> Performance of monthly fire drill for 4/2022 unavailable for review</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>Carehome operator will post fire drill monthly in carehome monthly calendar to remind care giver, to perform fire drill timely,</p>	<p>6/9/22</p> <p>22 AUG -1 AM 1:36</p> <p>STATE OF MICHIGAN DEPARTMENT OF STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-87 <u>Personal care services.</u> (a) 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.</p> <p><u>FINDINGS</u> Resident #1 – Care plan provided from 5/21-5/22 states, "Assist patient to rotate positions every 2 hours"; however, no documented evidence this task is being performed</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>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-87 <u>Personal care services.</u> (a) 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.</p> <p><u>FINDINGS</u> Resident #1 – Care plan provided from 5/21-5/22 states, "Assist patient to rotate positions every 2 hours"; however, no documented evidence this task is being performed</p> <p>Resident #1 – Care plan provided from 5/21-5/22 states, "Check incontinence pad every 2 hours and as needed"; however, no documented evidence this task is being performed</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>Remind note for turning schedule and check incontinence pad. every 2 hours ^{at} the next client bed.</p>	<p>6/9/22</p> <p>22 AUG -1 AM 1:36</p> <p>STATE OF MARYLAND DEPARTMENT OF STATE SERVICES</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-87 <u>Personal care services.</u> (c)(2) The primary care giver shall, in coordination with the case manager, make arrangements for each expanded ARCH resident to have:</p> <p>Pneumococcal and influenza vaccines and any necessary immunizations following the recommendations of the Advisory Committee of Immunization Practices (ACIP);</p> <p><u>FINDINGS</u> Resident #1 – No documented evidence resident received or was offered flu vaccine</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;"><u>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</u></p> <p style="text-align: center;">Care home operator found the resident's proof of flu vaccination and filed it in vaccine section of resident's chart</p>	<p style="text-align: right;">5/18/22</p>

STATE OF HAWAII
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STATE LICENSING

22 AUG -1 AM 36

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services. (c)(6)</u> 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>Coordinate care giver training, hospital discharge, respite, home transfers and other services as appropriate. Facilitate, advocate and mediate for expanded ARCH residents, care givers and service providers to ensure linkages and provision of quality care for the optimal function of the expanded ARCH resident;</p> <p><u>FINDINGS</u> Resident #1 – No documented evidence SCG #1 received training by resident's case manager on <u>appropriate health related topics.</u></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>SCG #1 received training by resident's case manager on 6/4/22</p> <p><i>(Handwritten initials)</i></p> <p style="text-align: right;">STATE OF HAWAII DOH-ORCA STATE LICENSING</p>	<p>6/4/22</p> <p style="text-align: right;">22 JUN 17 PM 2:11</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services. (c)(6)</u> 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>Coordinate care giver training, hospital discharge, respite, home transfers and other services as appropriate. Facilitate, advocate and mediate for expanded ARCH residents, care givers and service providers to ensure linkages and provision of quality care for the optimal function of the expanded ARCH resident;</p> <p><u>FINDINGS</u> Resident #1 – No documented evidence SCG #1 received training by resident's case manager on appropriate health related topics.</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>put new hire checklist to receive training by resident's case manager on orientation period, 6/4/22</p>	<p>22 JUN 17 PM 2:11</p> <p>STATE OF HAWAII DOH-DOCA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services. (c)(6)</u> 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>Coordinate care giver training, hospital discharge, respite, home transfers and other services as appropriate. Facilitate, advocate and mediate for expanded ARCH residents, care givers and service providers to ensure linkages and provision of quality care for the optimal function of the expanded ARCH resident;</p> <p>FINDINGS Resident #1 – Medication orders dated 8/1/21 and 1/10/22 states, “Crush tabs, open caps for medication administration if having difficulty swallowing unless otherwise indicated”; however, <u>no documented evidence training was provided to caregivers by the resident’s case manager on how to prepare and administer crushed meds and capsules.</u></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>We have training and document by case manager on 7/20/19 only. SCG #1 never get training. SCG #1 got training by resident's case manager on 6/4/22.</p> <p style="text-align: right; transform: rotate(-90deg);">STATE OF HAWAII DOH-CHCA STATE LICENSING</p>	<p>6/4/22 ✓</p> <p style="text-align: center;">22 JUN 17 PM 2:11</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services. (c)(6)</u> 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>Coordinate care giver training, hospital discharge, respite, home transfers and other services as appropriate. Facilitate, advocate and mediate for expanded ARCH residents, care givers and service providers to ensure linkages and provision of quality care for the optimal function of the expanded ARCH resident;</p> <p><u>FINDINGS</u> Resident #1 – Medication orders dated 8/1/21 and 1/10/22 states, "Crush tabs, open caps for medication administration if having difficulty swallowing unless otherwise indicated"; however, no documented evidence training was provided to caregivers by the resident's case manager on how to prepare and administer crushed meds and capsules.</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>will review special task of nursing procedures with case manager once a year.</p> <p>and put new hire checklist to get train by resident's case manager & sign the form on orientation periods.</p>	<p>6/4/22</p>

STATE OF OHIO
BOH-041A
STATE LICENSING

22 JUN 17 PM 2:11

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(9) 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>Provide ongoing evaluation and monitoring of the expanded ARCH resident's status, care giver's skills, competency and quality of services being provided;</p> <p><u>FINDINGS</u> Resident #1 – No documented evidence the resident's case manager was evaluating and monitoring SCG #1's caregiver skills as training was not provided by the CM on health topics relevant to resident's medical care and needs</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)(9) 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>Provide ongoing evaluation and monitoring of the expanded ARCH resident's status, care giver's skills, competency and quality of services being provided;</p> <p><u>FINDINGS</u> Resident #1 – No documented evidence the resident's case manager was <u>evaluating and monitoring</u> SCG #1's caregiver skills as training was not provided by the CM on health topics relevant to resident's medical care and needs</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>operator will coordinate and communicate with case manager immediately when new caregiver are added to care home.</p> <p>operator will coordinate with case manager on a quarterly basis to ensure that all SCG have been evaluated & monitored for their expanded resident status, caregiver skills, competency & quality of services being provided</p> <p>will post a reminder along with caregiver quarterly training sheet in</p>	<p>22 AUG-1 AM 1:36</p>

refrigerator to remind SCG. 6/9/22

Licensee's/Administrator's Signature: Young Yoon

Print Name: Young Yoon

Date: 6/17/22

22 JUN 17 PM 2:12
STATE OF HAWAII
DOH-ORCA
STATE LICENSING

Licensee's/Administrator's Signature: _____

Young Yoon

Print Name: _____

Young Yoon

Date: _____

8/1/22

STATE OF MICHIGAN
BOH-21626
STATE LICENSING

22 AUG -1 AM 1:37