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Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Pohai Nani `Ahui Malie	CHAPTER 100.1
Address: 45-090 Namoku Street, Kaneohe, Hawaii 96744	Inspection Date: October 27, 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.

23
09/27/2022

	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 Care Giver (PCG) and all 27 indicated substitute care givers (SCG) did not have a fieldprint background check.</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;"><i>see Attached</i></p>	<p style="text-align: center;"><i>2-28-23</i></p>

see attached

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Part 1:

23 APR 28 12 44

11-100.1-17 Records and Reports (a) (4)

Deficiency was corrected as follows:

Obtained evidence of field print background checks for 25 care home caregivers including PCG.

SCG #26 not listed

SCG #25 has resigned

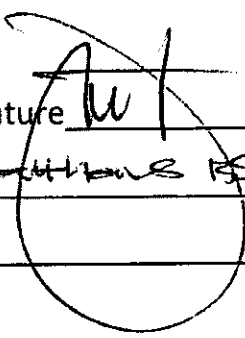
Part 2:

To prevent this deficiency from recurring in the future we have updated our policy to include the following:

All individuals being considered for employment in care homes must provide evidence of a fieldprint background check including evidence of fingerprinting. This must be submitted prior to individual being hired and for existing employees evidence must be provided every year x 2 years and then every other year thereafter.

Completed date 2.28.23

Licensee's Administrator's Signature



Print Name

William E. Matthews BSJ. RN

Date

3.2.23

	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's #4, 13, 17, 18, and 25 – No evidence of initial positive tuberculosis skin test.</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;"><i>See Attached</i></p>	<p style="text-align: center;"><i>2/1/23</i></p>

Part 1:

11-100.1-17 Records and Reports (a) (4)

Deficiency was corrected as follows:

Obtained copies of initial (+) PPD tests that required chest x-rays from employees identified in POC

Part 2:

To prevent this deficiency from recurring in the future we have updated our policy to include the following: All individuals being considered for employment must provide hard copy evidence of a (+) PPD that required a chest x-ray. This must be submitted prior to individual being hired.

Completed date 2.1.23

Licensee's Administrator's Signature

Print Name

Date

3.2.23

Judith F. Matthews, RN, PA

	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's #4, 13, 17, 18, and 25 – No evidence of initial positive tuberculosis skin test.</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 style="text-align: center;"><i>See Attached</i></p>	<p style="text-align: center;"><i>2/1/23</i></p> <p style="text-align: right; vertical-align: bottom;"><i>23</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.</p> <p><u>FINDINGS</u> Toxic chemicals were unsecured under kitchen sink.</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;"><i>see Attached</i></p>	<p style="text-align: center;"><i>2/28/23</i></p>

2/28/23 12:00 PM

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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Part 1:

11-100.1-14 Food Sanitation (f)

'23 APR 20 11:00

Deficiency was corrected as follows:

- All toxic chemicals were secured in locked cabinets , in each care home kitchen

Part 2:

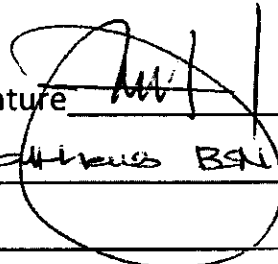
To prevent this deficiency from recurring in the future all Care Home staff responsible for handling toxic chemicals will be provided training.

Instructions for the correct procedure include

- Unlocking the cabinet and removing chemicals when needed
- Keeping cabinets locked and secure at all times
- Returning chemicals to cabinets when not in use

Completed date 2.28.23

Licensee's Administrator's Signature



Print Name

Judith E. Matthews BSN RN

Date

3.2.23

	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 – No signed physician’s or APRN’s order for “Senexan-S 50-8.6 mg tab. Take 2 tabs by mouth once daily. Hold for loose stools” available for review.</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><i>See Attached</i></p>	<p><i>2/28/23</i></p>

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23 APR 21 4:11 PM

Part 1:

'23 000 28 9:07

11-100.1-15 Medications (e)

Deficiency was corrected as follows:

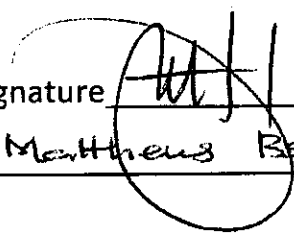
Signed orders received from ordering physician authorizing "Senexan-S 50-8.6 mg tab. Take 2 tabs by mouth once daily. Hold for loose stools".

Part 2:

To prevent this deficiency from recurring in the future we have updated our policy to include the following: RN will maintain unsigned verbal orders in separate area at nurse's station and hold until verbal orders clarified and confirmed with physician signature.

This policy will include that RN will f/u q 48 hours with physician's office on status of clarification.

Completed date 2.28.23

Licensee's Administrator's Signature 

Print Name Judith E. Matthews RN, RN

Date 3.2.23

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-19 <u>Resident accounts.</u> (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative.</p> <p><u>FINDINGS</u> Resident #1 – No documented evidence of a signed statement indicating who is responsible for resident's funds.</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><i>See Attached</i></p>	<p>12/31/22</p>

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Part 1:

23 APR 20 12:13

11-100.1-19 Residents Accounts

Deficiency was corrected as follows:

- Authorization of Facility to Handle Personal Funds (GSS #222) initiated for each resident , also referred to as Resident Trust Account (RTA)

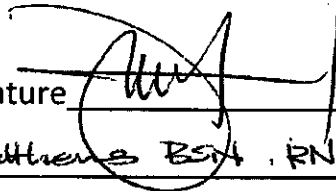
Part 2:

To prevent this deficiency from recurring in the future the Care Home Admission Checklist has been revised to include the tool GSS # 222, also referred to as Resident Trust Account (RTA). GSS # 222 for resident # 1 has been included.

During the admission process RN will review GSS #222 with resident and responsible party/POA and obtain signatures as required. We will refer to this admission checklist during all future admissions.

Completed date 12-31-22

Licensee's Administrator's Signature



Print Name Justine E. Matthews BSN, RN

Date 3.2.23

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (h)(3) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p>All Type I ARCHs shall comply with applicable state laws and rules relating to sanitation, health, infection control and environmental safety;</p> <p><u>FINDINGS</u> Care home is not using the required cleaning routine for dish sanitation.</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;"><i>See Attached</i></p>	<p style="text-align: center;">3/1/23</p>

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Part 1:

11-100.1-23 Physical Environment (h) (3)

23 03/23 12:15

Deficiency was corrected as follows:

- Procedure for Care Home Hand/Dish Washing posted in all care home kitchens

Part 2:

To prevent this deficiency from recurring in the future all Care Home staff responsible for hand washing dishes will be provided training to include demonstration. Instructions for the correct procedure are posted in all care home kitchens for staff reference.

Completed date 3-1-23

Licensee's Administrator's Signature 

Print Name Judith E. Matthews ESN EN

Date 3-2-23

Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____

[Handwritten Signature]

Judith E. Matthews BSW R

3-2-25

23 APR 24 5:15