

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Loretta G. Domingo	CHAPTER 100.1
Address: 1419 Ala Leleu Street, Honolulu, Hawaii 96818	Inspection Date: December 8, 2023 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
OFFICE OF HEALTH CARE ASSURANCE
STATE LICENSING SECTION

24 JAN 10 AM 03:35

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-8 Primary care giver qualifications. (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall:</p> <p>Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current;</p> <p>FINDINGS Employee #1 – No documented evidence of six (6) continuing education hours within the past twelve (12) months on file.</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><i>-PCG completed training on Personal Care of Patients/Residents Patients with Arthritis, Care of Patient with Constipation, Conflict Management</i></p> <p><i>-Bloodborne Pathogen training</i></p>	<p><i>12/08/2023-</i> <i>12/10/2023</i></p> <p><i>12/11/2023</i></p> <p style="text-align: right;">24 JAN 10 AM 0:35</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-8 <u>Primary care giver qualifications.</u> (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall:</p> <p>Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current;</p> <p><u>FINDINGS</u> Employee #1 – No documented evidence of six (6) continuing education hours within the past twelve (12) months on file.</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><i>PCG and caregivers will attend and complete at least 2 continuing education courses quarterly. PCG to review Office of Health Care Assurance requirements monthly to ensure satisfactory and completion on a timely manner. SCG will also review requirements and A2ET tender to monthly to update as necessary.</i></p>	<p style="text-align: right;">24 JAN 10 PMO:35</p> <p style="text-align: right; font-size: small;">STATE OF MICHIGAN DEPARTMENT OF COMMUNITY COLLEGE ASSISTANCE</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)(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> Employee #2 – No documented evidence of a current First Aid certification on file.</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><i>SCG attended and completed CPP/AED / First Aid training; certification is valid for 2 years (ID # 62AEDB5F). Certification is placed in ARAH binder and may be removed upon request.</i></p>	<p style="text-align: center;"><i>12-19-2023</i></p> <p style="text-align: center;">24 JAN 10 PM 0:35</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)(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> Employee #2 – No documented evidence of a current First Aid certification on file.</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><i>PCG will note certification dates and advise caregivers of impending expiration. PCG and SCG will review APatt binder monthly and update as needed to ensure documentation is current.</i></p>	<p style="text-align: right;">24 JAN 10 10:35</p> <p style="text-align: right; font-size: small;">STATE OF NEW HAMPSHIRE DEPARTMENT OF SERVICES FOR THE DEAF AND HEARING IMPAIRED</p>

	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> Employee #2 - No documented evidence of a current cardiopulmonary resuscitation (CPR) certification on file.</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><i>SCG completed CPR training and received his certification #10 62AEDB5F.</i></p>	<p style="text-align: right;"><i>12-19-2023</i></p> <p style="text-align: right;">24 JAN 10 PM 03:35</p> <p style="text-align: right; font-size: small;">STATE OF MICHIGAN CHILDREN'S SERVICES</p>

	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> Employee #2 – No documented evidence of a current CPR certification on file.</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><i>PLG placed copy of certification in ARCA binder and forwarded copy to OHCA supervisor via email on 12/11/2023. PLG to review and maintain ARCA binder periodically to ensure compliance with department requirements. SLO to also review ARCA binder and update or inform PLG of any impending expirations and/or necessary actions to be made</i></p>	<p style="text-align: right;">24 JAN 10 AM 34</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(2) 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 able to provide personal care to the residents, including bathing, dressing, transferring, feeding, and transporting residents, and be able to provide care as stipulated in the schedule of activities or care plan;</p> <p><u>FINDINGS</u> Employee #2 – No documented evidence of a current primary care giver (PCG) training for the substitute care giver to provide personal care to the residents, including bathing, dressing, transferring, feeding, and transporting residents, and be able to provide care as stipulated in the schedule of activities or care plan.</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>SCG completed training on Personal Care of Patients/Residents and Bloodborn pathogens.</i></p>	<p style="text-align: right;"><i>12/13/2023</i></p> <p style="text-align: right;"><i>12/19/2023</i></p> <p style="text-align: right;">24 JAN 10 AM 34</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(2) 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 able to provide personal care to the residents, including bathing, dressing, transferring, feeding, and transporting residents, and be able to provide care as stipulated in the schedule of activities or care plan;</p> <p><u>FINDINGS</u> Employee #2 – No documented evidence of a current PCG training for the substitute care giver to provide personal care to the residents, including bathing, dressing, transferring, feeding, and transporting residents, and be able to provide care as stipulated in the schedule of activities or care plan.</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>PCG will renew APETT binder regularly to ensure all training requirements are current and available for review upon request. SCG to renew APETT binder monthly for OHCA compliance.</i></p>	<p style="text-align: right;">STATE OF MICHIGAN DEPT. OF HEALTH STAFF SERVICES</p> <p style="text-align: right;">24 JAN 10 NO 34</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms.</p> <p><u>FINDINGS</u> Resident #1 – Physician ordered “Refresh Tears 0.5%” solution and “Flonase” nasal spray. Aforementioned medications without medication label on the bottle.</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>PCG affixed labels (with resident name, prescribing doctor, dosage and requirements/instructions) on OTC medications (Refresh Tears) and reserved original box of medications (Flonase).</i></p>	<p style="text-align: center;"><i>12/08/2023</i></p> <p style="text-align: center;">24 JAN 10 AM 34</p> <p style="text-align: center;">STATE OF CONNECTICUT DEPARTMENT OF SOCIETY SERVICES</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms.</p> <p><u>FINDINGS</u> Resident #1 – Physician ordered “Refresh Tears 0.5%” solution and “Flonase” nasal spray. Aforementioned medications without medication label on the bottle.</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><i>PCG to label all OTC medications, maintain/retain original box containing medication label to ensure medication is accurate per resident's care plan. SCG will also review and inspect all medications have labels affixed.</i></p>	<p style="text-align: right;">24 JAN 10 110:34</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-16 <u>Personal care services.</u> (h) A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed.</p> <p><u>FINDINGS</u> Resident #1 – No documented evidence of schedule or activities, including daily personal care needs performed from January 2023 to December 2023 on file.</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>	<p>24 JAN 10 AM 34</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-16 <u>Personal care services.</u> (h) A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed.</p> <p><u>FINDINGS</u> Resident #1 – No documented evidence of schedule or activities, including daily personal care needs performed from January 2023 to December 2023 on file.</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><i>PCG will complete a schedule of activities and maintain daily personal care needs with documentation; and review and assess plan as needed. SCG to review residents' binder for daily completion of documentation regularly.</i></p>	<p style="text-align: right;">24 JAN 10 AM 34</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>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;</p> <p><u>FINDINGS</u> Resident #1 – No documented evidence of progress notes in residents' chart from January 2023 to November 2023.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p style="text-align: center;">STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES STAFF DEVELOPMENT</p> <p style="text-align: center;">24 JAN 10 AM 03:34</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>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;</p> <p><u>FINDINGS</u> Resident #1 -- No documented evidence of progress notes in residents' chart from January 2023 to November 2023.</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><i>PCG to document progress of residents monthly and/or as deemed necessary (conversations/interactions with PCP, dentists and other interdisciplinary, outings with family/friends, document gifts, etc.)</i></p> <p><i>SCG to also review resident binder regularly to ensure all necessary documentation/forms are updated.</i></p>	<p style="text-align: center;">24 JAN 10 AM 034</p> <p style="text-align: center;">STATE OF CONNECTICUT DEPARTMENT OF CORRECTIONS</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 receipts for expenditures, and a current inventory of resident's possessions.</p> <p><u>FINDINGS</u> Resident #2 – No documented evidence of a current inventory of resident belongings on file. Last inventory conducted in 2020.</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>PCG will have resident complete and review inventory of belongings every quarter to ensure accuracy.</i></p> <p style="text-align: right; font-size: small;">STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES STATE LICENSING</p>	<p style="text-align: right;"><i>12/2/2023</i></p> <p style="text-align: right;">24 JAN 10 AM 34</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 receipts for expenditures, and a current inventory of resident's possessions.</p> <p><u>FINDINGS</u> Resident #2 – No documented evidence of a current inventory of resident belongings on file. Last inventory conducted in 2020.</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><i>PLG to review and have residents complete the inventory of belongings quarterly for accuracy and document as needed.</i></p> <p><i>SCG to review resident binder regularly to ensure accuracy.</i></p>	<p style="text-align: right;">24 JAN 10 AIO:34</p> <p style="text-align: right; font-size: small;">STATE OF NEW JERSEY STATE LICENSING</p>



Licensee's/Administrator's Signature: Kathleen Ho

Print Name: Kathleen Ho

Date: 12-24-2023

STATE OF MICHIGAN
Department of
STATE LICENSING
24 JAN 10 AM 34