Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Olalani Senior Care, LLC	**CHAPTER 100.1**
Address: **45-217 William Henry Road, Kaneohe, Hawaii 96744**	**Inspection Date: April 24, 2024 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 PER HAR 11-100.1-3(e)(2). IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

FAILURE TO CORRECT CITED DEFICIENCIES AS PER THE PLAN OF CORRECTION COULD RESULT IN REFUSAL TO RENEW YOUR LICENSE PER HAR 11-100.1-3(e)(3).

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 Food sanitation. (d) Potentially hazardous food shall meet proper temperature requirements during storage, preparation, display, service, and transportation. **FINDINGS** SCG reports cooking foods for residents' meals to 100°F	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 Food sanitation. (d) Potentially hazardous food shall meet proper temperature requirements during storage, preparation, display, service, and transportation. **FINDINGS** SCG reports cooking foods for residents' meals to 100°F	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** 1.Had an inservice with staff members of food sanitation deficiency. Chapter 100.1-14 under Food Sanitation which included but not limited to Food Procurement, Storage, Preparation was discussed. 2."Olalani Senior Care, LLC Nutrition & Dietary Policies and Procedures" which was developed by Olalani Senior Care RD, Nutrition Concepts, LLC., was copied and a copy was distributed to each staff member. Contents of Policies and Procedures, under the subject of "Food Preparation, Handling and Storage" which was divided into Sections of: a.Handwashing b.Preparation and Handling c.Cutting Boards d.Storage e.Defrosting Frozen Foods. Under this section is #9 which states that: "All meats will be heated to a safe minimum internal temperature. Pork and pork products will be cooked	04/29/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; **FINDINGS** Resident #1,2 – Annual TB clearance unavailable for review Submit a copy with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected Olalani Senior Care, LLC carehome has new Admission/Readmission and Annual Checklist for Residents that include but not limited to Admission History and Physical; Annual Physical Exam, 2-Step and Yearly TB Clearances, immunizations, etc. The list is usually visited a minimum of every 4-6 months for each resident to make sure that none of the necessary paperwork is missed or missing. On March 21, 2024 when Residents #1 and #2 were brought to their PCP (has the same PCP) for a P.E., TB Clearance Test and Immunizations if any was due at that time, Dr. B. L. told caregivers that both residents did not need TB Clearances at that time. Unfortunately, staffs did not question PCP of the reason why she said that both residents did not need the yearly TB Clearances. Both residents were brought to Lanakila Health Center for their yearly TB Clearances and both tested negative for TB disease. Certificates attached.	07/03/2024

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☒	§11-100.1-17 Records and reports. (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; **FINDINGS** Resident #1,2 – Annual TB clearance unavailable for review Submit a copy with plan of correction.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** 1 Held a meeting with staff of the missing TB Clearances for 2 residents. Admission / Readmission / Annual List were re-introduced to staffs and was discussed and reviewed for updates and completeness. Will continue to use 'List' for each resident to avoid missing important/necessary paperwork, such as TB Clearances. 2.PCG, Carehome manager or designated substitute will recheck charts every 4-6 months and randomly during charting for the presence and completeness of needed paperwork. Will refer and cross-check with Updated Checklist for new Admissions/Readmission/Annual Checklist for each resident. 3.The "DOH TB Clearance Manual" was also introduced to staffs and the new 'TB Clearance Forms and the 'TB Symptom Screen' Forms were reviewed and discussed.	07/03/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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 Resident #1 – MAR shows lidocaine patch applied on 7/6/23 and 7/13/23; however, response to medication not documented	PART 1 **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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** Resident #1 – MAR shows lidocaine patch applied on 7/6/23 and 7/13/23; however, response to medication not documented	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** 1.Inservice with PCG and staff informing them of deficiency of not documenting the response of medication, Lidocaine Patch 4% applied to resident. Emphasized to staff members that it is imperative to maintain medical records of resident's and most importantly to document important notes, results, etc. in the resident's medical record weekly, monthly, and as necessary for transparency to the continuity of care for the resident. All records or documentations to include but not limited to: MARs, Progress Notes, Treatments, Diet, Activity, overall reactions to medications, (be it effective or ineffective); evaluations of plan of care, etc. and any incidences that occurred must be completed right away. 2.All records documented and deemed done at that time should also be printed and placed in resident's medical record immediately. 3.The PCG or designated substitute will be checking	04/26/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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; FIND..GS Resident #1 – Monthly progress notes unavailable from 8/2023-3/2024	PART 1 **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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** Resident #1 – Monthly progress notes unavailable from 8/2023-3/2024	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** 1.Inservice with PCG and staff informing them of deficiency of no monthly documentation of resident #1 progress notes. Discussed and emphasized to staff members the imperativeness to maintain medical records of resident's and most importantly to document important notes, results, etc. in the resident's medical record weekly, monthly, and as necessary for transparency to the continuity of care for the resident. All records or documentations to include but not limited to: Progress Notes, MARs, Treatments, Diet, Activity, overall reactions to medications, (be it effective or ineffective); evaluations of plan of care, etc. and any incidences that occurred must be completed right away. 2.All records documented and deemed done at that time should also be printed and placed in resident's medical record immediately for DOH consultants' or any authority's review. 3.The PCG or designated substitute will be checking the resident's medical record for the presence,	04/26/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(4) During residence, records shall include: Entries describing treatments and services rendered; **FINDINGS** Resident #1 – Physician's order dated 8/10/23 states, "Monitor for LH or ↓BP since she isn't eating as much"; however, no documented evidence frequency of order was clarified with physician. Submit updated physician's order with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. Made an appointment with the Physician's office APRN to inform her of the Physician's order written on 8/10/23, with 'missing documentation evidence of the frequency of the BP order when it was written. Also, there was no documentation noted that the order was clarified by the doctor. A copy of the 'Physician's Order Form' where the BP order was written dated 8/10/23 was left at the doctor's office as was requested by APRN for the doctor to review and sign at a later date. The cardiologist reviewed the deficiency, wrote a new BP order with the frequency included and signed the order. The 'POF' form was picked up and place in the resident's chart. Copy attached.	07/02/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(4) During residence, records shall include: Entries describing treatments and services rendered; **FINDINGS** Resident #1 – Physician's order dated 8/10/23 states, "Monitor for LH or ↓BP since she isn't eating as much"; however, no documented evidence frequency of order was clarified with physician Submit updated physician's order with plan of correction.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** 1.Had an inservice with staff with new deficiency Informed/reiterated to staff that all Physicians' and APRNs' orders written on the Physician's Order Forms including but not limited to medication orders, treatment orders, wound care orders must be checked and reviewed when newly written, by 2 staffs when a resident comes back from a doctor's office or when it comes in as a fax order, and most importantly that the order is complete to include frequency of procedure. 2.For Treatment orders the following must be checked by the on-duty staff and rechecked by the PCG or a designated staff to make sure nothing is missed. -kind of treatment ie. Blood Sugar checks, Blood Sugar Monitoring Checks, Wound Care, etc. -how often to take or do the procedure -know resident's parameters and what is normal for resident -document treatments in 'Daily Monitoring Flowsheet' 3. RN, PCG and designated substitute will randomly check the residents' Medical Record for the	07/02/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(4) During residence, records shall include: Entries describing treatments and services rendered; **FINDINGS** Resident #1 – No documented evidence that the fluid order (1/23/24) , "drink 1.5 L of water per day" is being followed	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(4) During residence, records shall include: Entries describing treatments and services rendered; **FINDINGS** Resident #1 – No documented evidence that the fluid order (1/23/24) , "drink 1.5 L of water per day" is being followed	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** 1.Inservice done with OSC staff and discussed deficiency of 'no documentation of fluid order' even though the 1500ccs fluid order was being followed and taken by Resident #1. Reiterated and emphasized to staff members the imperativeness to maintain medical records of resident's and most importantly to document important notes such as fluid intake; tolerance of intake, and maybe outcome of ordered intake, daily in the resident's 'Daily Monitoring Flowsheet.' Documentation should be done daily and as necessary for transparency to the continuity of care for the resident. All records or documentations to include but not limited to: 'Daily Monitoring Flowsheet,' Progress Notes, MARs, Treatments, overall reactions to medications, (be it effective or ineffective); must be completed daily, weekly and PRN. 2. RN, PCG and designated substitute will randomly check the residents' Medical Record for the last PMD/APRN order, making sure that	04/25/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary. FINDINGS Resident #1 – Incident report for emergency department visit on 5/31/23 unavailable for review	PART 1 **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary. **FINDINGS** Resident #1 – Incident report for emergency department visit on 5/31/23 unavailable for review	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** 1.Inservice with PCG and staff informing them the necessity of maintaining records written in the resident's medical record weekly, monthly, and as necessary for transparency to the continuity of care for the resident. All records or documentations to include but not limited to: Incident Reports, MARs, Progress Notes, Treatments, overall reactions to medications and any incidences that occurred must be completed right away. 2.All records documented and deemed done at that time should also be printed and placed in resident's medical record or Care Home Folder immediately for review. 3.The PCG or designated substitute will be checking the resident's medical record and/or Care Home Folder for the presence, appropriateness, and completeness of documents weekly, monthly and after an ER visit. PCG/ Designated Staff will report to RN for incomplete and missing records. Incident Report attached.	04/24/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-83 Personnel and staffing requirements. (5) In addition to the requirements in subchapter 2 and 3: Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents. **FINDINGS** PCG – Only three (3) hours of annual continuing education hours completed. Submit proof of nine (9) hours of completed continuing education hours. Hours will be credited towards the 2024 annual inspection.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. PCG located the Certificates of the Nine (9) missing hours of continuing education in the other Care Home Folder II (Hokulaki Senior Living, LLC). Certificates taken out of the wrong Care Home Folder and placed in the Olalani Senior Care Home II Folder which is the correct Folder where the certificates would have been during the annual inspection. (Copy of Certificates Attached) Completion Date: April 26, 2024	04/26/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-83 Personnel and staffing requirements. (5) In addition to the requirements in subchapter 2 and 3: Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents. **FINDINGS** PCG – Only three (3) hours of annual continuing education hours completed Submit proof of nine (9) hours of completed continuing education hours. Hours will be credited towards the 2024 annual inspection.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** 1.Had a meeting with Staff and reviewed the 'Personnel Form' created for all employees to track down all necessary paperwork needed for the Annual Inspection, which includes Inservices and Conferences attended. A form that lists Inservices and Conferences attended and the number of continuing education attended by the employee yearly has also been in use by OSC personnel. Forms are checked by PCG or Care Home Manager for the authenticity of certificates then signed by RN. 2.PCG or designated substitute will be in-charged in placing the employee certificates in the Care Home Folder. Will be randomly checked every 3-4 months by the PCG and designated substitute.	04/26/2024

Licensee's/Administrator's Signature: _____

Print Name: MYRIAM R TABANIAG

Date: 07/03/2024