Office of Health Care Assurance

**State Licensing Section**

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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| **Facility's Name: Pohai Nani Good Samaritan** | **CHAPTER 90** |
| **Address:**<br>**45-090 Namoku Street, Kaneohe, Hawaii 96744** | **Inspection Date: February 13 & 14, 2025 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 |
|---|---|---|---|
| ☒ | §11-90-8 Range of services. (a)(3)<br>Service plan.<br><br>The initial service plan shall be developed prior to the time the resident moves into the facility and shall be revised if needed within 30 days. The service plan shall be reviewed and updated by the facility, the resident, and others as designated by the resident at least annually or more often as needed;<br><br>**FINDINGS**<br>Resident #1 – Current service plan (10/16/24) was not updated to address frequent bladder incontinence, as noted on progress notes on 10/17/24, 10/28/24, 10/24/24, 11/21/24, 12/7/24, and 12/10/24. Service plan indicated resident is continent of bladder and bowel.<br>*Submit a copy of the revised service plan with your plan of correction (POC).* | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>Updated the service plan to reflect the assistance with incontinences. | 2/14/25 |

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| ☒ | §11-90-8 Range of services. (b)(1)(F) Services.<br><br>The assisted living facility shall provide the following:<br><br>Nursing assessment, health monitoring, and routine nursing tasks, including those which may be delegated to unlicensed assistive personnel by a currently licensed registered nurse under the provisions of the state Board of Nursing:<br><br>**FINDINGS**<br>Resident #1 - No documentation that the certified nurse aide (CNA) on duty informed or notified the licensed nurse of the two (2) small openings noted inside the resident's bottom on 1/8/25. | PART 1<br><br>**Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** | |

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Licensee's/Administrator's Signature: Kelona Lopes-Silva

Print Name: Kelona Lopes-Silva

Date: 02/18/2025

Licensee's/Administrator's Signature: 

Print Name: Kelona lopes-silva

Date: 04/27/2025