Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Lorenzo Care Home, LLC	**CHAPTER 100.1**
Address: **98-1591 Hoomaike Street, Pearl City, Hawaii 96782**	**Inspection Date: September 3, 2020 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.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (n) Self administration of medication shall be permitted when it is determined to be a safe practice by the resident, family, legal guardian, surrogate or case manager and primary care giver and authorized by the physician or APRN. Written procedures shall be available for storage, monitoring and documentation. **FINDINGS** Resident #1, self administers "NovoloLog Flex Pen" and tests blood glucose levels prior to each meal. However, 1. No evidence of a determination for safety by the resident's family and physician/APRN 2. No written procedures available for storage, monitoring and documentation.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

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	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, glucometer readings recorded are not consistent with glucometer machine readings. For example: 1. On 9/1/20, a.m. - record reads 201 versus 271 2. On 9/2/20, noon - record reads 248 versus 288 3. On 9/2/20, p.m. - record reads 210 versus 310 4. On 9/3/20, a.m. - record reads 203 versus 243 5. On 9/3/20, p.m. - record reads 214 versus 244	**PART 1** **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: _____

Print Name: _____

Date: _____