

Office of Health Care Assurance

State Licensing Section

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Superior Care Group L.L.C.	CHAPTER 100.1
Address: 2115 A Gertz Lane, Honolulu, Hawaii 96819	Inspection Date: February 12, 2021 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.

STATE OF HAWAII  
DOH-GHCA  
STATE LICENSING  
APR 22 12:34

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u> (d) The primary caregiver or licensee acting as the primary caregiver must be present in the Type I ARCH at all times unless the primary caregiver or licensee acting as the primary caregiver has secured a substitute caregiver to provide temporary coverage for the primary caregiver or licensee acting as the primary caregiver.	<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>SCG #1 and SCG #2 obtained a copy of their two step TB clearance from Lanakila on February 2021            The documentation provided by the SCG has been filed in personnel/ staffing binder for future references.</p> <p style="text-align: right;">STATE OF HAWAII            DOH-CHCA            STATE LICENSING</p>	<p>11/6/2020</p> <p>12/3/2020</p> <p><del>01/22/21</del></p> <p>2/12/21</p> <p>21 APR 22 P12:34</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (d) The primary caregiver or licensee acting as the primary caregiver must be present in the Type I ARCH at all times unless the primary caregiver or licensee acting as the primary caregiver has secured a substitute caregiver to provide temporary coverage for the primary caregiver or licensee acting as the primary caregiver.  <b>FINDINGS</b> Substitute care giver (SCG) #1 & SCG #2 - No documentation of two-step tuberculosis (TB) clearance. Submit a copy of a single TB skin test for each with the plan of correction (POC).	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Superior care group L.L.C. will require all SCG to have completed a two-step TB clearance and obtain a copy for documentation prior to being hired for employment. To ensure and prevent a similar deficiency from recurring, my plan is to follow a step by step guideline using a document checklist to ensure that all required documents are completed and filed.</p> <p style="text-align: right;">STATE OF HAWAII DOH-OHCA STATE LICENSING</p>	<p style="text-align: center;"><i>Approved</i></p> <p style="text-align: center;">2/12/21</p> <p style="text-align: right;">21 APR 22 PM 2:34</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-13 <u>Nutrition.</u> (a) The Type I ARCH shall provide each resident with an appetizing, nourishing, well-balanced diet that meets the daily nutritional needs and diet order prescribed by state and national dietary guidelines. To promote a social environment, residents, primary care givers and the primary care giver's family members residing in the Type I ARCH shall be encouraged to sit together at meal times. The same quality of foods provided to the primary care givers and their family members shall be made available to the residents unless contraindicated by the resident's physician or APRN, resident's preference or resident's family.  <b>FINDINGS</b> Lunch consisted of beef stew, tossed salad with dressing, sugar free jello, water and Pepsi. There was no milk substitution.	<p style="text-align: center;">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>Yes, to correct this deficiency, I contacted DOH registered dietitian, Annette Jackson, per Ms. Annette - milk can be substituted with "milk w/ cocoa"</i></p> <p><i>02-13-2021 onward, milk w/ cocoa will be used as a substitute for milk if residents desire.</i></p>	<p style="text-align: center;">2/13/21</p>

STATE OF HAWAII  
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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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.  <b>FINDINGS</b> Resident #1 - No physician order for "Tylenol 325 mg Take 2 tabs orally every 4 hours as needed for pain" recorded on the November 2020 and December 2020 medication records prior to order dated 12/14/20.	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p style="text-align: center;">21 APR 22 12:34</p>

STATE OF HAWAII  
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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.  <b>FINDINGS</b> Resident #1 - No physician order for "Vitamin C 500 mg 1 tab by mouth daily" recorded on the November 2020 & December 2020 medication records prior to order dated 12/14/20. However, the order of 12/14/20 was written "ascorbic acid 500 mg as needed for cold sxs [symptoms]." The medication has been taken daily.	<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>Yes, clarified with physician's order dated on 12.14.2020. Clarification was obtained for "ascorbic acid" 500mg. Physician has confirmed that ascorbic acid is <sup>given</sup> <del>not</del> given routine medication <del>will</del> be given to the resident daily and taken orally</i></p>	<p style="text-align: center;">2/16/21</p>

STATE OF HAWAII  
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STATE OF HAWAII  
 DEPARTMENT OF HEALTH  
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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><b>FINDINGS</b> Resident #1 - "Multiple vitamins-minerals 'Take by mouth' ordered 11/25/20 without the dosage and frequency specified. Complete order was dated 12/14/20.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p style="text-align: center;">21 APR 22 P12:35 STATE OF HAWAII DOH-OHCA STATE LICENSING</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-23 Physical environment. (g)(3)(I)(i) Fire prevention protection.  Type I ARCHs shall be in compliance with, but not limited to, the following provisions:  Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either:  For each such non-certified resident there must be a responsible adult on the premises of the home at all times that the non-certified resident is present in the home, and there must never be a stairway which must be negotiated for emergency exit by such non-certified resident;  <b>FINDINGS</b> Resident # 1 - No self-preservation certification at the time of admission. Self-preservation certification was dated 12/14/20.	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p style="text-align: right;">21 APR 22 P12:35 STATE OF HAWAII DOH-ONCA STATE LICENSING</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-23 <u>Physical environment</u> (g)(3)(D)(i) Fire prevention protection.  Type I ARCHs shall be in compliance with, but not limited to, the following provisions:  Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either:  For each such non-certified resident there must be a responsible adult on the premises of the home at all times that the non-certified resident is present in the home, and there must never be a stairway which must be negotiated for emergency exit by such non-certified resident;  <b>FINDINGS</b> Resident # 1 - No self-preservation certification at the time of admission. Self-preservation certification was dated 12/14/20.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>Signed self-preservation form will be strictly enforced as a requirement prior or upon admission. No admission of any resident if any of the required forms are missing or incomplete. To ensure and prevent a similar deficiency, a checklist will be recurring, and consists of forms and documents required to complete any admission of any resident.</i></p> <p style="text-align: right;">STATE OF HAWAII DOH-CHCA STATE LICENSING</p>	<p style="text-align: center;">2/12/21</p> <p style="text-align: right;">21 APR 22 P12:35</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-23 <u>Physical environment (j)(1)</u> Waste disposal: Every Type I ARCH shall provide a sufficient number of watertight receptacles, acceptable to the department for rubbish, garbage, refuse, and other matter. These receptacles shall be kept closed by tight fitting covers; <b>FINDINGS</b> Bathroom receptacle did not have a tight fitting cover.	<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>Yes, I have purchased six trash cans with tight fitting covers and replaced those in the two bathrooms and in the four resident's bedrooms also.</i></p>	<p style="text-align: center;">2/13/21</p>

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STATE OF HAWAII  
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Licensee's/Administrator's Signature:



Print Name: Shanelle C. Baxa

Date: 04/2/21

Licensee's/Administrator's Signature:



Print Name: Shanelle C. Baxa

Date: 5-20-21


Licensee's/Administrator's Signature:



Print Name: Shanelle C. Baxa

Date: 5-20-21

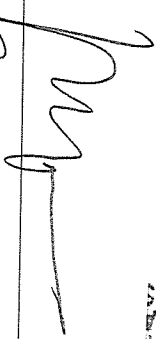
Licensee's/Administrator's Signature:



Print Name: Shanelle C. Baxa

Date: 06-07-2021

Licensee's/Administrator's Signature:



Print Name: Shanelle C. Baxa

Date: 07/21/21

FORM 2