

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Marie Malunao, LLC	CHAPTER 100.1
Address: 98-801 Ahikoe Street, Suite B, Kapolei, Hawaii 96707	Inspection Date: October 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
STATE LICENSING SECTION

21 OCT 20 P 3:15

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 Medications. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver.</p> <p>FINDINGS Resident #1 - "Acetaminophen 500 mg tab Take 1-2 tabs orally every 6 hours as needed" ordered 9/2/21; however, the number of tablets was not indicated when the medication was taken on 9/3/21 at 8 a.m.</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;">21 OCT 20 P3:15</p> <p style="text-align: center;">STATE OF HAWAII DEPARTMENT OF HEALTH STATE ENGINEER</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-15: <u>Medications, (m)</u> All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #1 - "Acetaminophen 500 mg tab Take 1-2 tabs orally every 6 hours as needed" ordered 9/2/21; however, the number of tablets was not indicated when the medication was taken on 9/3/21 at 8 a.m.	<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>CG will highlight ("Take 1-2 tablets orally every 6 hours as needed") Rx medication label and on MAR; indicate how many tabs was given as per prescription.</p> <p>CG will also label on MAR the date, time, and dosage amount given, and initial.</p> <p>PCG will review all medications and if possible, have MD be specific on the dosage given. Will recheck to make sure the prescription bottle label matches the script, medication, and MAR.</p>	<p style="text-align: center;">10/12/21</p> <p style="text-align: center;">21 OCT 20 P 3:15</p> <p style="text-align: center;">STATE OF HAWAII SPECIAL SERVICES</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	<p>§11-100.1-17 <u>Records and reports.</u> (a)(3) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review.</p> <p>Documentation of date of referral and admission, referral agency with address and telephone number, place or source from which admitted, physician, APRN, dentist, ophthalmologist, optometrist, psychiatrist, and all other medical or social service professionals who are currently treating the resident, next of kin, legal guardian, surrogate or other legally responsible agency;</p> <p><u>FINDINGS</u> Resident #1 - No emergency information. No record of the legal guardian, DD case manager, physician, or psychiatrist.</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;">Emergency information completed.</p>	<p style="text-align: center;">10/12/21</p> <p style="text-align: right;">21 OCT 20 P 3:15 <small>STATE OF HAWAII BOH-920A STATE LICENSES</small></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(3) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>Documentation of date of referral and admission, referral agency with address and telephone number, place or source from which admitted, physician, APRN, dentist, ophthalmologist, optometrist, psychiatrist, and all other medical or social service professionals who are currently treating the resident, next of kin, legal guardian, surrogate or other legally responsible agency;</p> <p><u>FINDINGS</u> Resident #1 - No emergency information. No record of the legal guardian, DD case manager, physician, or psychiatrist.</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>To insure that the emergency information is completed; PCG will include emergency information sheet with admission packet. Admission packet to include: (see attachment)</p>	<p>STATE OF HAWAII DEPT. OF HEALTH STATE LICENSING</p> <p>21 OCT 20 P 3:16</p>

Prior to admitting Client into our home. Dept of Health requires these forms to be filled:

- Physical examination record. Includes: diagnosis, mental, functional and behavioral status. Must be signed by physician.
- T.B. Clearance. Two step PPD skin test or documentation of a positive PPD skin test and one subsequent chest x-ray.
- Level of Care. Must be signed by physician.
- Medication orders/treatment orders. Must be signed by physician. (includes any nutritional supplements; Ensure, Nutren, etc.)
- Diet orders. Must be signed by physician.
- Self-preserving documentation. Must be signed by physician.
- Transfer summary.
- Resident Emergency Information.

STATE OF HAWAII
FOR THE
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21 OCT 20 P 3:16

	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 - Progress notes did not include observations of the resident's tolerance to diet, response to prn guaifenesin and acetaminophen, weekly activities outside the home with the community learning services-individual (CLS-I) worker.</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>21 OCT 20 P 3:16</p> <p>STATE OF HAWAII DEPARTMENT OF HEALTH STATE LICENSING</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (f)(4) General rules regarding records:</p> <p>All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency.</p> <p><u>FINDINGS</u> Resident #1 - No individual service plan (ISP) in the record.</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>Current annual ISP printed and attached to resident's chart.</p>	<p>10/12/21</p> <p style="text-align: right;">21 OCT 20 P 3:16</p> <p style="text-align: right; font-size: small;">STATE OF HAWAII DEPT. OF SOCIAL SERVICES STATE LICENSING</p>

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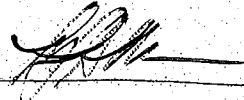
Licensee's/Administrator's Signature: _____



Print Name: Marie Malunao

Date: 10/12/2021

Licensee's/Administrator's Signature: _____



Print Name: Marie Malunao

Date: 11/16/2021

STATE OF HAWAII
DEPARTMENT OF
STATE LICENSING

21 OCT 20 P 3:17