

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Soriano Care Home	CHAPTER 100.1
Address: 2307 North school Street, Honolulu, Hawaii, 96819	Inspection Date: September 15, 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) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

STATE OF HAWAII
DEPT. OF HEALTH
STATE LICENSING

21 DEC 10 A7:55

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><u>FINDINGS</u> Substitute care giver #1- No documented evidence of training by primary care giver.</p>	<p>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>① Training was provided to substitute caregiver no. 1. It's now in the file.</p> <p>②</p> <p>STATE OF HAWAII DON CHOI STATE LICENSING</p> <p>21 DEC 10 A 7:55</p>	12-8-21

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><u>FINDINGS</u> Substitute care giver #1- No documented evidence of training by primary care giver.</p>	<p>PART 2</p> <p><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>I will make reminder on my personal notebook or calendar. to train any new substitute caregiver.</i></p>	<p><i>12-8-21</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (l) Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets.</p> <p>FINDINGS Resident #2: No special diet menu for "no concentrated sweets, no added salt" ordered by physician. No documented evidence that special diet is being provided as ordered.</p>	<p>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>Diet order for the residents no. 2 has been corrected to regular diet.</i></p> <p>STATE OF HAWAII DOM-2002 STATE LICENSING</p> <p>21 DEC 10 A7:56</p>	12-8-21

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (l) Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets.</p> <p><u>FINDINGS</u> Resident #2: No special diet menu for "no concentrated sweets, no added salt" ordered by physician. No documented evidence that special diet is being provided as ordered.</p>	<p>PART 2</p> <p><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>I will make a reminder on my notebook on my notebook to always check diet order after annual physical exam.</i></p>	<p><i>12-8-21</i></p>

Licensee's/Administrator's Signature: Helen Sorianu

Print Name: HELEN SORIANO

Date: 12-4-21

STATE OF HAWAII
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