

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Mary Ann's	CHAPTER 100.1
Address: 745 Puu Kala Street, Pearl City, Hawaii 96782	Inspection Date: February 16, 2022 Annual Inspection

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.

22 FEB 10 P2:45
STATE OF HAWAII
OFFICE OF HEALTH CARE ASSURANCE
STATE LICENSING

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 Physical environment. (g)(3)(I) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>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:</p> <p>FINDINGS Residents #1, #2, & #3 – Are all currently certified as non-self-preserving. Maximum number allowed in care home is two (2).</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>PCG reach out with family, we all agreed to do re-assessment. On Feb 17, 2022 MD did the assessment, resident literally 2/18/22 did everything that MD asked per to do.</i></p> <p>STATE OF HAWAII DOH-CHCA STATE LICENSING</p>	<p>22 MAR 10 P 2:45</p>

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STATE OF HAWAII
DEPARTMENT OF
STATE LICENSING

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 Case management qualifications and services. (c)(4)</p> <p>Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Update the care plan as changes occur in the expanded ARCH resident care needs, services and/or interventions;</p> <p>FINDINGS</p> <p>Resident #1 - Registered Nurse case manager (RN CM) care plan initiated 11/16/21 for Risk of infection, wound still indicates to use:</p> <ul style="list-style-type: none"> - Cefalexin 500mg take 1 tab three times a day x 5 days for infection. - Mupirocin ointment twice a day x7 days to affected area. <p>Both infections have resolved.</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>PCC corrected this deficiency by making sure that Cephalexin 500mg (d/c 11/21/21) and Mupirocin Ointment (d/c 11/23/21) also reflects on resident's nursing care plan — mfoad</i></p>	<p>2/17/22</p> <p>STATE OF HAWAII DOH-ORCA STATE LICENSING</p>

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Licensee's/Administrator's Signature: MAKAY

Print Name: MAKAY ANN FOARD

Date: 3/2/22

22 MAR 10 P 2:45
STATE OF HAWAII
DOH-CHCA
STATE LICENSING

Licensee's/Administrator's Signature: Supond

Print Name: MARK ANN FORD

Date: 5/18/22

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DCH-CHCA
STATE LICENSING

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