Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Hawaii Kai Retirement Community Phase I & II	**CHAPTER 90**
Address: **42-8446 Kawaihae Sreet, Honolulu, Hawaii 96825**	**Inspection Date: January 7, 2022 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
☒	§11-90-8 Range of services. (a)(2) Service plan. A service plan shall be developed and followed for each resident consistent with the resident's unique physical, psychological, and social needs, along with recognition of that resident's capabilities and preferences. The plan shall include a written description of what services will be provided, who will provide the services, when the services will be provided, how often services will be provided, and the expected outcome. Each resident shall actively participate in the development of the service plan to the extent possible; **FINDINGS** Resident #1 – Physician's orders dated, 1/26/21-9/17/21 states, "Blood pressure parameters for contacting MD: SBP less than 100; SBP greater than 160; DBP less than 50; DBP greater than 100, "Heart rate parameters for contacting MD: less than 60; greater than 100"; however, these parameters were not included in resident's service plan.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

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Licensee’s/Administrator’s Signature: _____

Print Name: _____

Date: _____