

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: ORI - 2C	CHAPTER 89
Address: 64-1510 Kamehameha Highway, Wahiawa, Hawaii 96786	Inspection Date: August 15, 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.**

STATE OF HAWAII  
HEALTH CARE ASSURANCE  
STATE LICENSING SECTION

22 SEP -6 P 2:14

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-3 <u>Licensure</u>. (d)(2) The caregiver and administrator shall also complete clearances from:</p> <p>Hawaii criminal justice data center - Federal bureau of investigation fingerprinting clearance.</p> <p><b><u>FINDINGS</u></b> Caregiver #1 – No current Fieldprint result available. Available results were from 2015 and 2018.</p>	<p>PART 1</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>Caregiver have a new Fingerprint dated 02/02/2021. Copy will be attached together with this POC.</p>	

22 SEP -6 P 2:14  
STATE OF HAWAII  
DEPARTMENT OF HEALTH  
DIVISION OF LICENSING

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-9 <u>General staff health requirements.</u> (a)(1) All individuals living in the facility including those who provide services directly to residents shall have documented evidence that they have had examination by a physician prior to their first contact with the residents of the home and thereafter as frequently as the department deems necessary. The examination shall be specifically oriented to rule out communicable disease and shall include tests for tuberculosis.</p> <p>If an initial tuberculin skin test is negative, a second tuberculin skin test shall be done after one week, but no later than three weeks after the first test. The results of the second test shall be considered the baseline test and shall be used to determine appropriate treatment follow-up. If the second test is negative, it shall be repeated once yearly thereafter unless it becomes positive.</p> <p><b><u>FINDINGS</u></b> Resident #1 and #2 – No initial/2 step tuberculosis clearance.</p>	<p>PART 1</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>All clients will be taking 2 steps TB test in October 2022 after a year of their single TB tests last year.</p>	<p>22 SEP -6 P2:14</p> <p>STATE OF HAWAII</p> <p>SENIOR CLERK</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (e)(1) Medications:</p> <p>All medicines shall be properly and clearly labeled. The storage shall be in a staff-controlled workcabinet /workcounter apart from either residents' bathrooms or bedrooms.</p> <p><b><u>FINDINGS</u></b> In resident's bedroom #1, an open box of Salonpas patches was left on drawer. Caregiver removed and secured during inspection.</p>	<p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p>72 SEP -6 P 2:14</p> <p>STATE OF HAWAII REGISTRY STATE LMS, INC</p>

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<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (e)(2) Medications:</p> <p>Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.</p> <p><b><u>FINDINGS</u></b> Resident #1 – Triamcinolone 0.1% cream did not have a cap.</p>	<p>PART 1</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>The case manager called in for a new refill to ensure that Triamcinolone 0.1% cream have a cap.</p> <p>The caregiver was advised that in the future report to the office and ask for a new refill for the medication that don't have cap or label, to ensure that all medication will be properly stored with cap.</p>	<p>08/16/22</p> <p>08/16/22</p> <p>22 SEP -6 P 2:11</p> <p>STATE OF MICHIGAN DOH-CALAS STACILSON, MIA</p>



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<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (e)(5) Medications:</p> <p>All medications and supplements, such as vitamins, minerals, and formulas shall be made available by written physician order and shall be based upon current evaluation of the resident's condition.</p> <p><b>FINDINGS</b>  Resident #1 – Physician's order was "Allergy Relief 12.5mg/5ml, Take 10ml by mouth every 6 hrs. as needed for rhinitis." Medication available was "Loratadine 5-mg/5ml SOLN, Take 10mg orally daily as needed for allergies."  Please clarify with physician.</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>Clarified with the physician regarding the instructions of Loratadine 5mg/ml Solution and Allergy Relief (Diphenhydramine). The doctor advised that Loratadine should be given daily and the Allergy Relief can only be given for severe allergy (PRN) in addition to the Loratadine.</p> <p>The MAR was revised and new label for the Loratadine have been changed to daily.</p> <p>The caregiver was advised that any changes with medication label coming from the pharmacy, to ask the case manager and clarify if the new instructions is ordered by the physician.</p>	<p>08/31/22</p> <p>09/01/22</p> <p>08/31/22</p> <p>22 SEP -6 P2:14</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (b)(2) During residence, records shall be maintained by the caregiver and shall include the following information:</p> <p>Observations of the resident's response to medication, treatments, diet, provision of care, response to activities programs, indications of illness or injury, unusual skin problems, changes in behavior patterns, noting the date, time and actions taken, if any, which shall be recorded monthly or more often as appropriate but immediately when an incident occurs;</p> <p><u>FINDINGS</u> Resident #1 – No July 2022 monthly observation of the resident.</p>	<p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p>22 SEP -6 P2:14</p> <p>STATE OF HAWAII DEPT. OF HEALTH STATE INSPECTION</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (c)            Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be submitted to the case manager within twenty-four hours from the time of the incident and shall be retained by the facility under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician shall be called immediately if medical care is necessary.</p> <p><b><u>FINDINGS</u></b>            Resident #1 – Adverse Event Report was filed in resident's binder.</p>	<p>PART 1</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>The Adverse Event Report was taken out from the resident's binder and filed it in the appropriate binder.</p> <p>The case manager was advised that in the future Adverse Event Form must not be filed in the individual resident's binder and should be filed in an appropriate binder, i.e. Adverse Event Reporting Binder.</p>	<p>08/16/22</p> <p>22 SEP -6 P2:15</p> <p>STATE OF ALABAMA            DEPT. OF HUMAN SERVICES            STATE LIAISON</p>



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Licensee's/Administrator's Signature: *Susanna F. Cheung*

Print Name: Susanna F. Cheung, President/CEO

Date: 09/01/2022

STATE OF CALIFORNIA  
DEPARTMENT OF  
STATE LICENSING

22 SEP -6 P2:15