

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Reyes Care Home	CHAPTER 100.1
Address: 94-931 A Lumihoahu Street, Waipahu, Hawaii 96797	Inspection Date: October 17, 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) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>. (b)(1)(I) Application.</p> <p>In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application:</p> <p>Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law;</p> <p><u>FINDINGS</u> Primary Care Giver (PCG), Substitute Care Giver (SCG) #1, SCG #2, SCG #3 – No current documented evidence stating no prior felony or abuse conviction in a court of law on file.</p> <p>Please provide a copy of your Fieldprint results with your plan of correction.</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>Fieldprint appointments were made and results included with this plan of correction.</p>	<p>11/28/2022</p> <p>23 JAN 19 AM 9:37</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (b) 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><u>FINDINGS</u> Observed "Aspirin", "Non-Aspirin" and various ointment packets and burn gel packets in the facility first aid kit. Substitute Care Giver removed medications from first aid kit and secured it during inspection.</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>23 JUN 19 09:38</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Physician order dated 10/1/22 to discontinue “Olmesartan Medoxomil 20mg 1 tab po q.d. hold for sbp <110.” However, medication is being recorded as being administered to resident from 10/1/22 to 10/6/22/22 on medication sheet.</p>	<p>PART 1</p> <p>Upon further review, this citation will be removed.</p>	<p>23 JAN 23 A9:27</p> <p>STATE OF HAWAII BOH-ONCA STATE LICENSING</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Physician order dated 10/1/22 for “Metoprolol Succinate 100mg tab po q.d.” Medication was not filled by pharmacy until 10/5/22 and no initials on medication sheet noting if medication was given to, held by, or refused by from 10/1/22 to 10/6/22.</p> <p>Please clarify with resident’s primary care provider.</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>23 JAN 19 A9:38</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> (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 made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary.</p> <p><u>FINDINGS</u> Resident #1 – No incident report available for review when resident was sent to Pali Momi Emergency Department on August 14, 2022.</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>This record was in storage and has been retrieved .</i></p> <p>STATE OF HAWAII DOH-CHO 61WEL1220202</p>	<p><i>12/2022</i></p> <p>23 JAN 19 A9:38</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. (g)</u> All information contained in the resident's record shall be confidential. Written consent of the resident, or resident's guardian or surrogate, shall be required for the release of information to persons not otherwise authorized to receive it. Records shall be secured against loss, destruction, defacement, tampering, or use by unauthorized persons. There shall be written policies governing access to, duplication of, and release of any information from the resident's record. Records shall be readily accessible and available to authorized department personnel for the purpose of determining compliance with the provisions of this chapter.</p> <p><u>FINDINGS</u> Resident #1 – Records provided from October 2021 through August 2022 was incomplete for department review. Resident's initial admission was dated 12/3/20 and was readmitted 9/9/22. Resident chart only contained information dating from 8/22/22 till present. Per SCG #2, records are secured in public storage facility.</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>Records for resident #1 were retrieved from storage.</p>	<p>12/2022</p> <p>23 JAN 19 19:38</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(D) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>A drill shall be held to provide training for residents and personnel at various times of the day or night at least four times a year and at least three months from the previous drill, and the record shall contain the date, hour, personnel participating and description of drill, and the time taken to safely evacuate residents from the building. A copy of the fire drill procedure and results shall be submitted to the fire inspector or department upon request;</p> <p><u>FINDINGS</u> Quarterly fire drills were not held at various times of the day. Fire drills conducted only between 8:30 a.m. to 10:30 a.m. for this inspection year.</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>23 JAN 19 A 9:38</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (o)(3)(B) Bedrooms:</p> <p>Bedroom furnishings:</p> <p>Each bed shall be supplied with a comfortable mattress cover, a pillow, pliable plastic pillow protector, pillow case, and an upper and lower sheet. A sheet blanket may be substituted for the top sheet when requested by the resident;</p> <p><u>FINDINGS</u> Bedroom #2 – Unoccupied bed of a shared bedroom was observed to have a pillow with no pliable plastic pillow protector. Furthermore, pillow had previously discharged resident's name written on pillow.</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>Discarded pillow that had the discharged residents name name on it. Replaced with a new pillow with a pliable plastic pillow protector.</p>	<p>10/22/2012</p> <p>'23 JAN 19 A9:39</p> <p>STATE OF CONNECTICUT DEPT. OF SOCIAL SERVICES STATE LICENSING</p>

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Licensee's/Administrator's Signature: Corazon Reyes

Print Name: CORAZON REYES

Date: 1/13/2023

23 JAN 19 19:39
STATE OF HAWAII
DEPARTMENT OF
STATE LICENSING