

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Pualei Care Home	CHAPTER 100.1
Address: 7246 Anakua Street, Honolulu, Hawaii 96825	Inspection Date: October 5, 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>§11-100.1-13 <u>Nutrition</u>. (k) Physician or APRN orders for nutritional supplements including vitamins, minerals, formula meals and thickening agents shall be updated annually or sooner as specified.</p> <p><u>FINDINGS</u> Resident #1 – Physician order dated 8/10/22 for diet states “soft foods, nectar thickened liquids,” however no order for thickening agent was obtained.</p> <p>Please provide a copy of a signed physician order 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>	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (5) In addition to the requirements in subchapter 2 and 3:</p> <p>Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents.</p> <p><u>FINDINGS</u> Substitute Care Giver #1 – Only 3 hours out of the required 12 hours of continuing education was available for department review.</p> <p><u>Repeat deficiency from 2021.</u></p> <p>Please provide nine (9) hours of continuing education 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>	

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____