

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Huapala Senior Care A, LLC	CHAPTER 100.1
Address: 2649 A Huapala Street, Honolulu, Hawaii 96822	Inspection Date: December 27, 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.

NOV 17 10:50

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><u>FINDINGS</u> Substitute Care Giver #1 – Initial tuberculosis clearance not signed by a physician or APRN.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <div style="border: 1px solid black; padding: 5px; margin: 20px auto; width: fit-content;"> <p>Initial tuberculosis clearance signed by physician on 8/15/2018 and has been placed in staff qualification binder.</p> </div>	<p style="text-align: center; font-size: 1.5em;">3/15/2018</p> <p style="text-align: center;">W</p> <p style="text-align: center; font-size: 0.8em;">29 APR 13 PM 3:41</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 – Order for Acetaminophen = 325 mg (2 tabs) orally every 6 hours as needed for pain and/or fever greater than 100F. Acetaminophen bottle available for resident contains 500 mg tabs, not 325 mg.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: 80%;"> <p>Educated both nurses on the importance of checking the bottle and ensuring the strength matches the current order received from the physician/APRN. Additionally reiterated that nursing staff should not place labels over the name, strength, or expiration date of the OTC medication to decrease room for error Acetaminophen 500mg bottle returned to residents POA. Acetaminophen 325mg bottle labeled and placed in medication cabinet under residents PRN medications</p> </div>	<p style="text-align: center;">12/28/22</p> <p style="text-align: center;">w</p> <p style="text-align: center;">23 JAN -9 P1:48</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> (f)(1) General rules regarding records:</p> <p>All entries in the resident's record shall be written in black ink, or typewritten, shall be legible, dated, and signed by the individual making the entry;</p> <p><u>FINDINGS</u> Resident #1 – September 2022 monthly summary written in blue ink.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p style="text-align: center;">23 JAN -9 P 1 :28</p>

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Licensee's/Administrator's Signature: _____

Joanna Vietor

Print Name: _____

Joanna Vietor

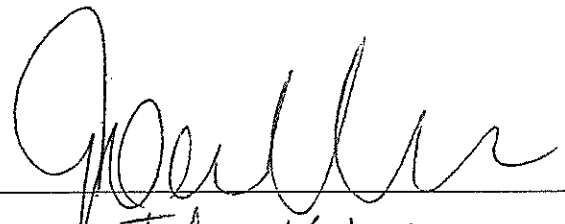
Date: _____

1/6/23

STATE OF ILLINOIS
DEPARTMENT OF
STATE LICENSING

23 JAN -9 P 1 :48

Licensee's/Administrator's Signature: _____



Print Name: _____

Joanna Victor

Date: _____

3/9/23

23 MAR 13 13:21
STATE OF CALIFORNIA
DIVISION OF LICENSING