

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: <b>Kaimuki Senior Care, L.L.C. (918)</b>	<b>CHAPTER 100.1</b>
Address: <b>918 12<sup>th</sup> Avenue, Honolulu, Hawaii 96816</b>	<b>Inspection Date: December 13 &amp; 14, 2022 Annual</b>

**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.**

23 NOV 2022 11:00

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (b) Menus shall be written at least one week in advance, revised periodically, dated, and followed. If cycle menus are used, there shall be a minimum of four weekly menus.</p> <p><b><u>FINDINGS</u></b> Menu was not followed. Lunch meal consisted of somen salad with tofu, romaine lettuce, cucumber, low fat milk, and coffee/tea; however, did not include garlic eggplant as stated on the menu.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (1) Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets.</p> <p><b><u>FINDINGS</u></b> No documented evidence that the diet order, "Minced, nectar thick," (ordered on 3/23/2022) was clarified with the physician to include the type of diet.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: 80%;"> <p>Residents' admission orders stated "NAS, Minced, Nectar Thick Liquids", AVS received from APRN on 3/23/22 reads Minced, Nectar Thick"</p> <p>Primary Care Physician faxed for clarification on diet order on 12/27/22, received clarification order back signed on 12/27/22</p> </div>	<p style="text-align: center;">12/27/22 W</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	<p>§11-100.1-15 <u>Medications.</u> (a)  All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms.</p> <p><b><u>FINDINGS</u></b>  Resident #1 – No medication label on over-the-counter Vitamin B12 supplement.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THE COF</b> DON reviewed with the nurses in the home the following medication administration guideline:</p> <ul style="list-style-type: none"> <li>• When a new medication order for over the counter is received from the MD/Nurse Practitioner Nurses must place an instruction label on “over the counter” medication bottles. Do not cover the medication name or the expiration date with the label. All staff be sure to check the label if written by Licensed Nurse to ensure it’s the correct OTC medication and label is correct</li> </ul> <p><b>HOW YOU ENCY</b></p>	<p style="text-align: center;">12/14/22 W</p>

Deficiency was corrected on 12/14/22 by SCG. A label was placed on the over-the-counter Vitamin B12 Supplement

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Licensee's/Administrator's Signature: \_\_\_\_\_

*Joanna Vsetor*

Print Name: \_\_\_\_\_

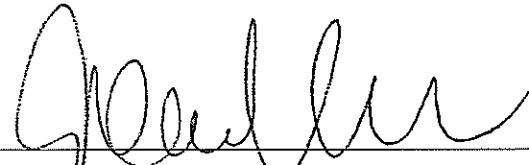
Joanna Vsetor

Date: \_\_\_\_\_

1/3/2023



Licensee's/Administrator's Signature: \_\_\_\_\_



Print Name: \_\_\_\_\_

Joanna Victor, RN

Date: \_\_\_\_\_

3/2/23