

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Lettie's (ARCH)	CHAPTER 100.1
Address: 739-D Judd Street, Honolulu, Hawaii, 96817	Inspection Date: July 19, 2021 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.

RECEIVED
APR 29 2022

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:</p> <p>Be currently certified in cardiopulmonary resuscitation;</p> <p><u>FINDINGS</u> PCG and SCG did not renew CPR and First Aid. Expired On 5/19/20. Please send copy with your Plan of Correction.</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> <p style="text-align: center;"><i>Enclosed are copies of CPR and First Cards, dated 07-28-21 - July 2023.</i></p> <p style="text-align: center;"><i>Sorry it expired, because of the Corona Virus, we couldn't attend any gatherings</i></p>	<p style="text-align: right;"><i>07-28/21</i> <i>July 2023</i></p> <p style="text-align: center;">21 NOV 17 P 3:22</p> <p style="text-align: center;">STATE OF HAWAII DOH-CERTIFICATION STATE LICENSING</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:</p> <p>Be currently certified in cardiopulmonary resuscitation;</p> <p><u>FINDINGS</u> PCG and SCG did not renew CPR and First Aid. Expired On 5/19/20. Please send copy with your Plan of Correction.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>Care giver & Substitute will double check CPR & First Aid before it expired</i></p>	

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<p><input checked="" type="checkbox"/> §11-100.1-10 <u>Admission policies.</u> (h) Residents requiring emergency admission to an ARCH or expanded ARCH, due to removal from their current placement by the department or other state agency and who lack immediate access to a physician or emergency room, and who are unable to provide a report of tuberculosis clearance within one year of admission, may be admitted to the ARCH or expanded ARCH if the resident obtains a chest x-ray indicating freedom from communicable tuberculosis within twenty-four hours after admission. The resident shall obtain a tuberculin skin test within three days after admission, as per departmental procedure. The resident shall also submit to a physical examination within one week after admission unless he or she has done so within three months prior to admission.</p> <p>FINDINGS Resident #1 – Chest x-ray done for tuberculosis for emergency admission to ARCH, but tuberculin skin test not done yet. PCG states she was told by QMC that she was positive, however I could not find any documentation by QMC. Please take in for 2-Step as soon as possible.</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> <p style="text-align: center;">Brought Resident NOI to Lanakila, Dept. of Health on-07-29-21- for TB Screening. Enclosed, is a copy of negative result of 2/2/21</p>	<p style="text-align: center;">STATE OF HAWAII DEPARTMENT OF HEALTH 21 NOV 17 P 3:22</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 - Mirtazapine 7.5mg ordered on Queen's discharge order but no bottle and not on Medication Administration Record (MAR). Please clarify with the primary doctor.</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> <p style="text-align: center;"><i>Resident #1 - Mirtazapine 7.5 mg - Called the doctor No longer on this medication D.C. when she was discharge that's the reason why there was no bottle</i></p>	<p style="text-align: right;"><i>07-28-21</i></p> <p style="text-align: center;">STATE OF HAWAII <small>Department of Health</small> STATE LICENSES DIV.</p> <p style="text-align: center;">NOV 17 P 3:23</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver.</p> <p>FINDINGS Resident #1 – Atorvastation 40mg and Aspirin 81mg ordered by doctor and filled on 7/8/21 but not on MAR and no order found. Please clarify with primary doctor.</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> <p style="text-align: center;"><i>Resident #1 - Went to the doctor on 08-06-21 - Enclosed is a copy of her medication which includes Aspirin 81mg & Atorvastatin 40mg 1 tab. qHS</i></p>	<p style="text-align: right;"><i>11-14-21</i></p> <p style="text-align: right;">STATE OF HAWAII 001-091-0000 STATE DEPARTMENT OF HEALTH</p> <p style="text-align: right;">NOV 17 13:23</p>

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Licensee's/Administrator's Signature: Leticia Tesoro

Print Name: Leticia Tesoro

Date: 04-29-22

Licensee's/Administrator's Signature: Leticia Tesoro

Print Name: Leticia Tesoro

Date: 3-19-22

Licensee's/Administrator's Signature: Leticia Tesoro

Print Name: Leticia Tesoro

Date: 11-14-21

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