

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Kina 'Ole Estate Elua, LLC	CHAPTER 100.1
Address: 45-225 William Henry Road, Kaneohe, Hawaii 96744	Inspection Date: April 10 & 11, 2023 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.**

STATE OF HAWAII  
DOT-DHCA  
STATE LICENSING

23 JUN 28 AM 03

	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><b><u>FINDINGS</u></b>  SCG #1 – Red light determination on Fieldprint background check. No documented evidence of approved appeal/exemption.</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> <p style="text-align: center;">Employee no longer works for Kina'ole.</p>	<p style="text-align: center;">05/17/2023</p> <p style="text-align: right;"> 23 JUN 28 AM 10 03  STATE OF HAWAII  DHH-ORCA  STATE LICENSING </p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p><b><u>FINDINGS</u></b> SCG #2 -- No current first aid certification.</p>	<p style="text-align: center;">PART 1</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> <p style="text-align: center;">YES, SCG completed a first aid class and turned in the certificate.</p>	<p style="text-align: center;">04/20/2023</p> <p style="text-align: center;">23 JUN 28 AM 03 STATE OF HAWAII DOH-DHCA STATE LICENSING</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<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 – Furosemide ordered 2/14/2023, includes hold parameter “hold for systolic blood pressure &lt;100.” Hold parameter not included on medication label.</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>YES, PCG put a “directions changed, refer to chart” sticker with “order date” on medication label.</p>	<p>04/11/2023</p> <p style="text-align: right;"> 23 JUN 28 AM 10:03  STATE OF HAWAII  DOH-QHCA  STATE LICENSING </p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p><b><u>FINDINGS</u></b> Resident #1 – Progress notes did not include observations of the resident's tolerance to Glucerna shake nutritional supplement (ordered 2/6/2023).</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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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (f)(4) General rules regarding records:</p> <p>All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency.</p> <p><b><u>FINDINGS</u></b> Substitute Care Giver (SCG) #1 – Documentation of initial/2-step tuberculosis clearance not available until second (2<sup>nd</sup>) day of annual inspection.</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> <p style="text-align: center;">YES, PCG checked SCG's file and assure that 2 step TB test was in her file.</p>	<p style="text-align: center;">04/11/2023</p> <div style="text-align: right; font-size: small;"> <p>23 JUN 28 AM 10:03</p> <p>STATE OF HAWAII DHE-ORCA STATE LICENSING</p> </div>

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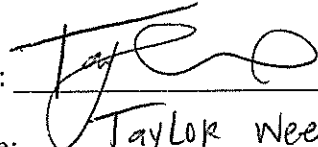
STATE OF HAWAII  
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23 JUN 28 AM 10:03

	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><b><u>FINDINGS</u></b> SCG #3 -- 9.5/12 continuing education hours completed within last year.</p>	<p style="text-align: center;">PART 1</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> <p>YES, SCG completed 2.5 hours of continuing education.</p>	<p style="text-align: center;">04/26/2023</p> <p style="text-align: right; vertical-align: bottom;"> <b>73 JUN 28 AM 02</b>  STATE OF HAWAII  DOH-DHCA  STATE LICENSING </p>

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



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

Taylor Neers

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

06/19/2023

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