

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

|  |   |
|--|---|
| Facility's Name: Selga, Natividad (ARCH)               | CHAPTER 100.1                             |
| Address: 45-933 Kealahala Place, Kaneohe, Hawaii 96744 | Inspection Date: September 7, 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.**

|                                     | <b>RULES (CRITERIA)</b>  | <b>PLAN OF CORRECTION</b>  | <b>Completion<br/>Date</b> |
|-------------------------------------|--|--|----------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-13 Nutrition. (l)<br/>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><br/>Resident #2: Physician order of 30oz fluid restriction per day. No documented evidence fluid intake is being monitored.</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> |                            |

|                                     | <b>RULES (CRITERIA)</b>  | <b>PLAN OF CORRECTION</b>  | <b>Completion Date</b> |
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Licensee's/Administrator's Signature: \_\_\_\_\_

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

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