

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Irene Della Adult Residential Care Home	CHAPTER 100.1
Address: 189 Maika Street, Wailuku, Hawaii 96793	Inspection Date: July 14, 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.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p><u>FINDINGS</u> Substitute Care Giver (SCG) – Annual Physical Exam states that she is well but also sees another physician and to “contact her also”. No documentation of clearance from other Physician.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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<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 – Olopatadine Ophthalmic solution and Artificial Tears were ordered by Physician on 3/29/23, however, eye drops did not appear on any medication administration records (MAR) and there are no Physician signed orders to discontinue either medication.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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☒	<p>§11-100.1-15 <u>Medications</u>. (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><u>FINDINGS</u> Resident #1 – Medication order for Furosemide changed from 40mg to 20mg PO QD on 7/10/23, however, July 2023 MAR had Furosemide 20mg PO QD for the entire month. Original medication order was not reflected accurately from 7/1/23 to 7/10/23.</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>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 Medications. (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year.</p> <p>FINDINGS Resident #2 – Medication orders are not reviewed and renewed every four (4) months.</p> <p>Repeat deficiency from 2019, 2020, and 2022.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;</p> <p><u>FINDINGS</u> Resident #1 – On annual physical examination, section for diagnosis says “see attached”, however, there is nothing attached to review.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____