

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Care Homes by Hale Makua	CHAPTER 100.1
Address: 1540 Lower Main Street, Wailuku, Hawaii 96793	Inspection Date: October 19, 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>§11-100.1-3 <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><u>FINDINGS</u> Substitute Care Giver #1 and #2 – Unable to determine fitness determination on printed Fieldprint background check result.</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>§11-100.1-20 <u>Resident health care standards.</u> (c) The primary and substitute care giver shall be able to recognize, record, and report to the resident's physician or APRN significant changes in the resident's health status including, but not limited to, convulsions, fever, sudden weakness, persistent or recurring headaches, voice changes, coughing, shortness of breath, changes in behavior, swelling limbs, abnormal bleeding, or persistent or recurring pain.</p> <p><u>FINDINGS</u> Resident #2 – No documented evidence that the facility notified the physician of 19 lb. weight gain (18.5% weight change) in one year.</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>§11-100.1-55 <u>Nutrition and food sanitation.</u> (1) In addition to the requirements in section 11-100.1-13 the following shall apply to all Type II ARCHs:</p> <p>A registered dietitian shall be utilized to assist in the planning of menus, and provide nutritional assessments for those residents identified to be at nutritional risk or on special diets. All consultations shall be documented;</p> <p><u>FINDINGS</u> Resident #2 – No documented evidence that the facility utilized the Consultant Registered Dietitian to provide nutritional assessment for resident with 19 lb. weight gain (18.5% weight change) in one year and taking Boost 1 bottle PO q AM.</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: _____