

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: J & K Care Home, LLC	CHAPTER 100.1
Address: 16-508 Ohe Street, Keaau, Hawaii 96749	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>§11-100.1-15 <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></p> <ul style="list-style-type: none"> Resident #1- No documentation of injection site given for Novolin 70/30 Flex Pen on 8/23/23, 9/18/23 and 9/30/23. Resident #1- Physician ordered to change Clonazepam 0.5 mg tablet by mouth twice daily as needed for agitation to Clonazepam 0.5 mg every six (6) hours as needed for agitation on 5/27/23, however no documentation of change in order reflected on May 2023 Medication Administration Record (MAR). Resident #1- Physician ordered Glucagon 1mg, Glucerna 8 ounce (oz) and Vitamin A&D ointment on 5/27/23, however no documentation of medication reflected on May 2023 MAR. 	<p>PART 1</p> <p>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>§11-100.1-17 <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><u>FINDINGS</u> Resident #1- No documentation that the physician was made aware of elevated blood pressure readings on 9/7/23, 9/16/23 and 9/23/23 in the progress notes.</p>	<p>PART 1</p> <p>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>§11-100.1-17 <u>Records and reports.</u> (b)(4) During residence, records shall include:</p> <p>Entries describing treatments and services rendered;</p> <p><u>FINDINGS</u> Resident #1- No documentation of blood sugar check on 10/18/23 prior to dinner.</p>	<p>PART 1</p> <p>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>§11-100.1-17 <u>Records and reports.</u> (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary.</p> <p><u>FINDINGS</u> Resident #2- No incident report written for emergency visit on 9/26/23.</p>	<p>PART 1</p> <p>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>§11-100.1-17 <u>Records and reports.</u> (f)(1) General rules regarding records:</p> <p>All entries in the resident's record shall be written in black ink, or typewritten, shall be legible, dated, and signed by the individual making the entry;</p> <p><u>FINDINGS</u></p> <ul style="list-style-type: none"> • Resident #1- June 2023 MAR was transcribed with blue ink. • Resident #2- Incident reports dated 7/3/23 and 7/8/23 were transcribed with blue ink. 	<p>PART 1</p> <p>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>§11-100.1-17 <u>Records and reports.</u> (f)(2) General rules regarding records:</p> <p>Symbols and abbreviations may be used in recording entries only if a legend is provided to explain them;</p> <p><u>FINDINGS</u> Resident #1- No legend to explain letter “H” observed on July 2023 MAR.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

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