

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name: Mana's Adult Care</b>	<b>CHAPTER 100.1</b>
<b>Address: 92-1177 Pueonani Street, Kapolei, Hawaii 96707</b>	<b>Inspection Date: September 12, 2023 Annual</b>

**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) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<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>  Primary Care Giver (PCG), Substitute Care Giver (SCG) #1, #2, #3, #4 – No Fieldprint results.</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>	

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	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><b><u>FINDINGS</u></b> PCG – DOH “TB Document F: State of Hawaii TB Clearance Form” was signed and dated 11/18/2022 by physician. However, determination of the tuberculosis (TB) clearance was not documented. Thus, there is no annual TB clearance.</p> <p>SCG #1 – Initial TB clearance was negative. SCG #1 has a negative chest x-ray result on 3/31/2023, but PPD skin test was not done. Thus, there is no annual TB clearance.</p> <p>Please submit a copy with your plan of correction.</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>	

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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 #4 – No First Aid certification.</p> <p>Please submit a copy with your POC.</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>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-12 <u>Emergency care of residents and disaster preparedness.</u> (c)  The licensee shall conduct regular quarterly rehearsals of emergency evacuation plans for staff and residents to follow in case of fire, explosion, or other civil emergency occurring in or within the environs of the facility.</p> <p><b><u>FINDINGS</u></b>  Fire drills were conducted between 10am and 11am only. PCG stated that residents participated in the fire drills, but their names were not recorded as participants.</p>	<p style="text-align: center;"><b>PART 1</b></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>§11-100.1-13 <u>Nutrition.</u> (a)  The Type I ARCH shall provide each resident with an appetizing, nourishing, well-balanced diet that meets the daily nutritional needs and diet order prescribed by state and national dietary guidelines. To promote a social environment, residents, primary care givers and the primary care giver’s family members residing in the Type I ARCH shall be encouraged to sit together at meal times. The same quality of foods provided to the primary care givers and their family members shall be made available to the residents unless contraindicated by the resident’s physician or APRN, resident’s preference or resident’s family.</p> <p><b><u>FINDINGS</u></b>  Resident #1 – Lunch meal was not served in an appetizing manner as foods were pureed together. Per PCG, pureeing foods together was requested by the resident’s family. There was no physician’s order.</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>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (c)            Separate compartments shall be provided for each resident's medication and they shall be segregated according to external or internal use.</p> <p><b><u>FINDINGS</u></b>            Resident #1 – External and internal medication stored in the same container. Corrected during inspection.</p>	<p style="text-align: center;"><b>PART 1</b></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>§11-100.1-15 <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><b><u>FINDINGS</u></b> Resident #1 – No indication for PRN use was provided for the following medications:</p> <ul style="list-style-type: none"> <li>- Acetaminophen 325mg, 2 tabs, every 4-6 hours, PRN</li> <li>- Flonase (Sub) Fluticasone 50mg, 1 puff to each nostril BID PRN</li> <li>- Clotrimazole (Sub) Betamethasone 1-0.05% cr, apply a small amount to affected area twice daily PRN</li> </ul>	<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>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.</p> <p><b><u>FINDINGS</u></b> Resident #1 – Discontinued medication was stored with current medication. Corrected during inspection.</p>	<p style="text-align: center;"><b>PART 1</b></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> (a)(8)  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 current inventory of money and valuables.</p> <p><b><u>FINDINGS</u></b>  Resident #1 – A list of personal items was not maintained.  Last updated on 1/5/2022.</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>	

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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><b><u>FINDINGS</u></b>            Resident #1 – Incident report was kept in resident’s binder.</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>	



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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><b><u>FINDINGS</u></b>            Resident #1 – Incident report was kept in resident’s binder.</p>	<p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p>	

	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<input checked="" type="checkbox"/>	<p>§11-100.1-21 <u>Residents' and primary care givers' rights and responsibilities.</u> (a)(1)(A) Residents' rights and responsibilities:</p> <p>Written policies regarding the rights and responsibilities of residents during the stay in the Type I ARCH shall be established and a copy shall be provided to the resident and the resident's family, legal guardian, surrogate, sponsoring agency or representative payee, and to the public upon request. The Type I ARCH policies and procedures shall provide that each individual admitted shall:</p> <p>Be fully informed orally or in writing, prior to or at the time of admission, of these rights and of all rules governing resident conduct. There shall be documentation signed by the resident that this procedure has been carried out;</p> <p><b><u>FINDINGS</u></b> Resident #1 – Only signed last page of the care home policy was available at home. Per PCG, resident's family has the rest of the original copy.</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>	

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

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

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