Office of Health Care Assurance

**State Licensing Section** 

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Jai Adult Residential Care Home	CHAPTER 100.1
Address: 1719 Perry Street, Honolulu, Hawaii, 96819	Inspection Date: November 3, 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
<ul> <li>§11-100.1-3 Licensing. (b)(1)(I) Application.</li> <li>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:</li> <li>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;</li> <li>FINDINGS</li> <li>Primary care giver: No documented evidence of Fieldprint background check.</li> </ul>	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
§11-100.1-3 <u>Licensing</u> . (b)(1)(I) Application.	PART 1	
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FINDINGS Substitute care giver #1: No documented evidence of Fieldprint background check.		

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion
			Date
$\square$	§11-100.1-3 <u>Licensing.</u> (b)(1)(I)	PART 2	
	Application.		
	In order to obtain a license, the applicant shall apply to the	FUTURE PLAN	
	director upon forms provided by the department and shall		
	provide any information required by the department to	USE THIS SPACE TO EXPLAIN YOUR FUTURE	
	demonstrate that the applicant and the ARCH or expanded	PLAN: WHAT WILL YOU DO TO ENSURE THAT	
	ARCH have met all of the requirements of this chapter. The following shall accompany the application:	IT DOESN'T HAPPEN AGAIN?	
	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;		
	FINDINGS		
	Substitute care giver #1: No documented evidence of		
	Fieldprint background check.		

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	<b><u>FINDINGS</u></b> Substitute care giver #2: No documented evidence of Fieldprint background check.		

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FINDINGS Substitute care giver #3: No documented evidence of Fieldprint background check.		

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	House hold member #2: No documented evidence of		
	Fieldprint background check.		

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<ul> <li>§11-100.1-8 Primary care giver qualifications. (a)(9) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall:</li> <li>Have achieved acceptable levels of skill and training in first aid, nutrition, cardiopulmonary resuscitation, and appropriate nursing and behavior management as required for care of all residents admitted to the Type I ARCH;</li> <li>FINDINGS Primary care giver: No documented evidence of cardiopulmonary resuscitation.</li> </ul>	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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FINDINGS Primary care giver: No documented evidence of cardiopulmonary resuscitation certification.		

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
RULES (CRITERIA)         \$11-100.1-9       Personnel, staffing and family requirements.         (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.         FINDINGS         Substitute care giver#3: No documented evidence of annual physical exam.	PLAN OF CORRECTION PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion
		Date
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§11-100.1-9 Personnel, staffing and family requirements. (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. <b>FINDINGS</b> Resident #1: No documented evidence of annual tuberculosis clearance.	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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-	$\square$	811-100.1-9 Personnel, staffing and family requirements	PART 2	Date
-		§11-100.1-9 Personnel, staffing and family requirements. (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. FINDINGS Resident #3: No documented evidence of annual tuberculosis clearance.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	Date

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<ul> <li>§11-100.1-9 Personnel, staffing and family requirements.</li> <li>(b)</li> <li>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.</li> <li>FINDINGS</li> <li>Substitute care giver #3: No documented evidence of annual tuberculosis clearance.</li> </ul>	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion
			Date
	<ul> <li>§11-100.1-9 Personnel, staffing and family requirements. (b)</li> <li>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.</li> <li>FINDINGS</li> <li>Substitute care giver #3: No documented evidence of annual tuberculosis clearance.</li> </ul>	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	
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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
§11-100.1-9 Personnel, staffing and family requirements. (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. <b>FINDINGS</b> House hold member #1: No documented evidence of annual tuberculosis clearance.	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion
			Date
	<ul> <li>§11-100.1-9 Personnel, staffing and family requirements.</li> <li>(b)</li> <li>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.</li> <li><b>FINDINGS</b></li> <li>House hold member #1: No documented evidence of annual tuberculosis clearance.</li> </ul>	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	
1			

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
§11-100.1-9 Personnel, staffing and family requirements. (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. <b>FINDINGS</b> House hold member #2: No documented evidence of annual tuberculosis clearance.	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion
			Date
	<ul> <li>§11-100.1-9 Personnel, staffing and family requirements.</li> <li>(b)</li> <li>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.</li> <li>FINDINGS</li> <li>House hold member #2: No documented evidence of annual tuberculosis clearance.</li> </ul>	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	
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RULES (CRITERIA)	PLAN OF CORRECTION	Completion
§11-100.1-13 Nutrition. (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit. <b>FINDINGS</b> Resident #1: No documented evidence of annual diet order.	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	Date

RULES (CRITERIA)	PLAN OF CORRECTION	Completion
	PLAN OF CORRECTION PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	Completion Date

ſ	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
	§11-100.1-13 <u>Nutrition.</u> (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit. <b>FINDINGS</b> Resident #2: No documented evidence of annual diet order.	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	Date

RULES (CRITERIA)	PLAN OF CORRECTION	Completion
§11-100.1-13 <u>Nutrition.</u> (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit. <b>FINDINGS</b> Resident #2: No documented evidence of annual diet order.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	Date

RULES (CRITERIA)	PLAN OF CORRECTION	Completion
§11-100.1-13 <u>Nutrition.</u> (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit. <b>FINDINGS</b> Resident #3: No documented evidence of annual diet order.	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	Date

RULES (CRITERIA)	PLAN OF CORRECTION	Completion
\$11-100.1-13 Nutrition. (i)         Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit.         FINDINGS         Resident #3: No documented evidence of annual diet order.	PLAN OF CORRECTION PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	Date

ſ	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
	§11-100.1-15 <u>Medications.</u> (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.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u>	Date
	physician or APRN, not to exceed one year.         FINDINGS         Resident #1: No documented evidence that medication orders were reevaluated from November 2022 to November 2023.         2023.	USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
§11-100.1-15 <u>Medications.</u> (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.	PART 2 <u>FUTURE PLAN</u>	Date
<b>FINDINGS</b> Resident #1: No documented evidence that medication orders were reevaluated from November 2022 to November 2023.	USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

RULES (CRITERIA)	PLAN OF CORRECTION	Completion
§11-100.1-15 <u>Medications.</u> (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.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u>	Date
<b>FINDINGS</b> Resident #2: Only one medication reevaluation order dated 6/5/23 since 4/9/21. No documented evidence medication were reevaluated at least every four months.	USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

RULES (CRITERIA)	PLAN OF CORRECTION	Completion
		Date
§11-100.1-15 <u>Medications.</u> (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.	PART 2 <u>FUTURE PLAN</u>	
<b>FINDINGS</b> Resident #2: Only one medication reevaluation order dated 6/5/23 since 4/9/21. No documented evidence medication were reevaluated at least every four months.	USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

ſ	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
	§11-100.1-15 <u>Medications.</u> (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.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u>	Date
	physician or APRN, not to exceed one year.         FINDINGS         Resident #3: No documented evidence that medication orders were reevaluated from November 2022 to November 2023.         2023.	USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
•	§11-100.1-15 <u>Medications.</u> (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.	PART 2 <u>FUTURE PLAN</u>	Date
	<b>FINDINGS</b> Resident #3: No documented evidence that medication orders were reevaluated from November 2022 to November 2023.	USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:	PART 1	
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;	DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	
<b><u>FINDINGS</u></b> Resident #1: Monthly progress notes do not reflect if resident tolerated medications and treatments.		

RULES (CRITERIA)	PLAN OF CORRECTION	Completion
§11-100.1-17 <u>Records and reports.</u> (b)(3)	PART 2	Date
During residence, records shall include:	PARI 2	
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;	<u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	
<b><u>FINDINGS</u></b> Resident #1: Monthly progress notes do not reflect if resident tolerated medications and treatments.		

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion
			Date
$\square$	§11-100.1-17 <u>Records and reports.</u> (h)(1)	PART 1	
	Miscellaneous records:		
		<b>DID YOU CORRECT THE DEFICIENCY?</b>	
	A permanent general register shall be maintained to record		
	all	USE THIS SDACE TO TELL US HOW VOU	
	admissions and discharges of residents;	USE THIS SPACE TO TELL US HOW YOU	
	FINDINGS	<b>CORRECTED THE DEFICIENCY</b>	
	FINDINGS General register reflects residents that are no longer in care		
	home.		
	nome.		

RULES (CRITERIA)	PLAN OF CORRECTION	Completion
		Date
§11-100.1-17 <u>Records and reports.</u> (h)(1) Miscellaneous records:	PART 2	
A permanent general register shall be maintained to record all	FUTURE PLAN	
admissions and discharges of residents;	USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT	
<b><u>FINDINGS</u></b> General register reflects residents that are no longer in care home.	IT DOESN'T HAPPEN AGAIN?	

Licensee's/Administrator's Signature:

Print Name:

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