Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Village Park Adult Residential Care Home	**CHAPTER 100.1**
Address: **94-101 Kauweke Place, Waipahu, Hawaii 96797**	**Inspection Date: January 5, 2024 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 PER HAR 11-100.1-3(e)(2). IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

FAILURE TO CORRECT CITED DEFICIENCIES AS PER THE PLAN OF CORRECTION COULD RESULT IN REFUSAL TO RENEW YOUR LICENSE PER HAR 11-100.1-3(e)(3).

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-3 Licensing. (b)(1)(I) Application. 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: 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** Primary Care Giver (PCG), Substitute Care Giver (SCG) #1, #2, #3 and Household Member (HM) #1 – No documented evidence the aforementioned have no prior felony or abuse convictions in a court of law. **Please email a copy of the Fieldprint results to your Nurse Consultant once they are obtained.**	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Primary Caregiver completed and bee emailed result. Substitute Caregiver #2 and #3 fingerfrint background check completed and emailed result. Substitute Caregiver #1 scheduled fingerprint background check on 1/16/24 result will be emailed after two weeks. Household Member #1 scheduled fingerprint on Jan.14, 2024 result will be emailed after two weeks.	01/17/2024

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☒	§11-100.1-3 Licensing. (b)(1)(I) Application. 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: 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** Primary Care Giver (PCG), Substitute Care Giver (SCG) #1, #2, #3 and Household Member (HM) #1 – No documented evidence the aforementioned have no prior felony or abuse convictions in a court of law. **Please email a copy of the Fieldprint results to your Nurse Consultant once they are obtained.**	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I created a checklist with all required staff clearances. This checklist includes 2 consecutive years of Fieldprint background checks. I, primary care giver will review the checklist every 6 months to ensure that all staff clearances are available and current. I will put a reminder on the front of my carehome binder which includes future dates I must review all staff clearances.	02/12/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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** SCG #1 and HM #1 – No current annual physical examination. **Please email a copy of the annual physical examinations to your Nurse Consultant once they are obtained.**	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Substitute Caregiver #1 and Household Member #1 Annual Physical Exam completed emailed copy of Physical Exam.	01/17/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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** SCG #1 and HM #1 – No current annual physical examination. **Please email a copy of the annual physical examinations to your Nurse Consultant once they are obtained.**	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I created a checklist with all required staff clearances. This checklist includes current annual physical examination of all the staff. I, the primary care giver will review this checklist every 6 months to ensure that all clearances are available and current. I will put a reminder on the front of my care home binder which includes the future dates I must review all staff clearances.	02/12/2024

	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. **FINDINGS** • SCG #2 and SCG #3 – No documented evidence of initial/2-step tuberculosis clearance. • HM #1 – No current annual tuberculosis clearance. **Please email a copy of the initial/2-Step and annual tuberculosis clearances to your Nurse Consultant once they are obtained.**	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Substitute care giver #2 called doctor office right after the visit to scheduled appointment for tuberculosis clearances and was scheduled on Jan. 26,2024. Substitute caregiver #3 was scheduled on Jan.19, 2024 will be emailed as soon as result is received. Household member # 1 tuberculosis clearance completed on October 7, 2023. will be emailed document.	02/12/2024

	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. **FINDINGS** • SCG #2 and SCG #3 – No documented evidence of initial/2-step tuberculosis clearance. • HM #1 – No current annual tuberculosis clearance. **Please email a copy of the initial/2-Step and annual tuberculosis clearances to your Nurse Consultant once they are obtained.**	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will created a checklist includes 2 step tuberculosis and annual tuberculosis clearances all of my staff . I, the primary caregiver will review the checklist every 6 months to ensure that all clearances available and current. I will put a reminder on the front of my care home binder which includes future dates I must review all staff clearances.	02/12/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Medication orders from 4/13/2023 = Risperidone 1 mg – Take 1 tablet by mouth 1 time each day if needed, and Triamcinolone 0.1% ointment – Two times a day if needed. Medication orders do not include PRN (as needed) indication. In addition, order for Triamcinolone 0.1% ointment does not specify location of use.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I called the resident 's physician and got a verbal order that includes the as needed indication for Risperidone and Triamcinolone. The Triamcinolone will include location/what part of the body will be administered. After the verbal order I will get the order signed by the resident's physician within 4 months from the verbal order date.	02/12/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – On 1/17/2023 over the counter artificial tears ordered for resident; however, eye drops never appeared on medication administration record and not currently available for administration. No order to discontinue eye drops available.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Artificial Tears supply was obtained, and complete order from the doctor was added to the MAR. Put the date ,time and initial every time I administered the medication.	02/12/2024

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☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – On 1/17/2023 over the counter artificial tears ordered for resident; however, eye drops never appeared on medication administration record and not currently available for administration. No order to discontinue eye drops available.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will go over the medication orders, labels, and recorded on the MAR . Every so often with another care giver I will read of all medications order while my substitute reads the medication label and then the MAR to ensure everything is available and that there are no discrepancies.	02/12/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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. **FINDINGS** Resident #1 – Medications reevaluated but not physically or electronically signed every four (4) months.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	01/17/2024

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☒	§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. **FINDINGS** Resident #1 – Medications reevaluated but not physically or electronically signed every four (4) months.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** For each resident I will make a list which includes the dates the medication orders were last signed. I will put this list on front of the resident's binder, so I know the next signed medication orders are due.	02/12/2024

Licensee's/Administrator's Signature: Marilou Peralta

Print Name: Marilou Peralta

Date: Jan 17, 2024

Licensee's/Administrator's Signature: Marilou Peralta

Print Name: Marilou Peralta

Date: Feb 12, 2024