

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name: Faithcare Senior Hale</b>	<b>CHAPTER 100.1</b>
<b>Address: 1108 Gulick Avenue, Honolulu, Hawaii 96819</b>	<b>Inspection Date: July 18, 2024 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 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).**

	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<input checked="" type="checkbox"/>	<p>§11-100.1-8 <u>Primary care giver qualifications.</u> (a)(10)  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:</p> <p>Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current;</p> <p><b><u>FINDINGS</u></b>  No documented evidence of six (6) continuing education hours within the last year.</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> (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> SCG #1 – No documented evidence of negative chest x-ray despite positive PPD history.</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>§11-100.1-13 <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.</p> <p><b><u>FINDINGS</u></b>            Resident #1 – No current annual diet 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>§11-100.1-13 <u>Nutrition.</u> (1) Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets.</p> <p><b><u>FINDINGS</u></b> Resident #1 – No documented evidence that the special diet order (cardiac diet) was clarified with the physician. In addition, no documented evidence that the special diet was provided as ordered as there are no special diet menus available for this diet 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> (a)  All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms.</p> <p><b><u>FINDINGS</u></b>  Resident #1 – Medication order for Metolazone = 2.5 mg po qd if weight &gt;119 lbs. Medication label = Metolazone 2.5 mg po qd prn if weight increases to 110 lbs. or higher. Medication label doesn't reflect medication 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> (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.</p> <p><b><u>FINDINGS</u></b> Resident #1 – Medication orders not reevaluated and signed by a physician or APRN every four (4) months.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p>	

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

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

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