

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| | |
|---|---|
| Facility's Name: Ho'omau Ke Ola I | CHAPTER 100.1 |
| Address: 84-1006 Farrington Highway, Waianae, Hawaii 96792 | Inspection Date: February 27, 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. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

STATE OF HAWAII
OFFICE OF HEALTH CARE ASSURANCE
STATE LICENSING SECTION

24 JUL 22 10:10

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|-------------------------------------|---|--|--|
| <input checked="" type="checkbox"/> | <p>§11-98-05 <u>Dietetic services.</u> (a) A special treatment facility shall have a written plan describing the organization and delivery of dietetic services and the utilization of the services of a qualified dietitian as required herein.</p> <p><u>FINDINGS</u> No documented evidence that the facility utilized the services of a qualified Consultant Registered Dietitian (RD). RD service contract and documentation of dietetic registration of RD were not submitted.</p> | <p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;">HKO contracts and utilizes a qualified RD. Signed contract, and CRD Card sent to OHCA via email on 05/06/2024.</p> <p style="text-align: center;">JUL 27 12:07</p> | <p style="text-align: right;">7/8/24</p> |

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| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|-------------------------------------|--|--|---|
| <input checked="" type="checkbox"/> | <p>§11-98-05 <u>Dietetic services.</u> (b) Overall supervisory responsibilities for the food service shall be assigned to a food service manager knowledgeable in food values and nutrition, or one who is receiving such training from the consultant dietitian.</p> <p><u>FINDINGS</u> No documented evidence that the food service manager received training from the Consultant RD. Evidence of training was not submitted.</p> | <p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;">Training materials signed by RD and FSM sent to OHCA via email on 05/06/2024.</p> <p style="text-align: center;">STATE OF OHIO DEPARTMENT OF HEALTH OHIO HEALTH CARE AGENCY 74 JUL 22 PM 12:07</p> | <p style="text-align: center;">7/8/24</p> |

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|-------------------------------------|--|---|---|
| <input checked="" type="checkbox"/> | <p>§11-98-05 <u>Dietetic services.</u> (c) Menus and food service shall meet the nutritional needs of the residents.</p> <p><u>FINDINGS</u> No documented evidence that the menus and food service meets the nutritional needs of the residents. Menus and menu evaluations were not submitted.</p> | <p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;">Menus and Menu Evolutions sent to OHCA via email on 05/06/2024.</p> <p style="text-align: right;">24 JUL 22 12:07</p> | <p style="text-align: center;">7/8/24</p> |

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Menu is on a six (6) week rotation cycle, and posted up at facility in the event that FSM is out. FSM & RD meet quarterly to review menu, and suitable menu substitutions.

APPROVED BY
 DATE

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|-------------------------------------|--|---|--|
| <input checked="" type="checkbox"/> | <p>§11-98-11 <u>Minimum standards for licensure: personnel.</u> (1) The administrator shall see that at least one staff member on each shift possesses a current First Aid certificate and CPR training. Recertification of training shall be required by all staff at least every two years.</p> <p><u>FINDINGS</u> Staff #2 – No documented evidence of a current First Aid and cardiopulmonary resuscitation (CPR) certifications on file.</p> | <p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;">Staff #2 is no longer employed with HKO.</p> <p style="text-align: right;"> <small>STATE OF MISSISSIPPI DEPARTMENT OF HEALTH DIVISION OF HEALTH SERVICES</small> <small>24 JUL 22 AM 10</small> </p> | <p style="text-align: right;">07/03/2024</p> |

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|-------------------------------------|--|--|--|
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Licensee's/Administrator's Signature: *AS Bortog*

Print Name: Alexis Bortog

Date: 07/08/2024

STATE OF TEXAS
JUL 22 2024

24 JUL 22 AM 10