

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

|   |   |
|---|---|
| <b>Facility's Name: Lavigne-Namoca Care Home</b>              | <b>CHAPTER 100.1</b>                        |
| <b>Address:<br/>98-609 Kaamilo Street, Aiea, Hawaii 96701</b> | <b>Inspection Date: May 16, 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>§11-100.1-13 <u>Nutrition.</u> (i)<br/>           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><br/>           Resident #2 – No documented evidence of current annual diet order by a physician or advanced practice registered nurse (APRN).</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> |                        |

|                                     | <b>RULES (CRITERIA)</b>   | <b>PLAN OF CORRECTION</b>  | <b>Completion Date</b> |
|-------------------------------------|---|--|------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-13 <u>Nutrition.</u> (i)<br/> 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><br/> Resident #2 – No documented evidence of current annual diet order by a physician or APRN.</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>§11-100.1-19 <u>Resident accounts.</u> (d)<br/>An accurate written accounting of resident's money and disbursements shall be kept on an ongoing basis, including receipts for expenditures, and a current inventory of resident's possessions.</p> <p><b><u>FINDINGS</u></b><br/>Resident #3 &amp; Resident #5 – No documented evidence of a current inventory of belongings on file.</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> |                        |

|                                     | <b>RULES (CRITERIA)</b>  | <b>PLAN OF CORRECTION</b>  | <b>Completion Date</b> |
|-------------------------------------|--|--|------------------------|
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Licensee's/Administrator's Signature: \_\_\_\_\_

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

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