

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: R & M Duran, L.L.C.	CHAPTER 100.1
Address: 94-628 Loa'a Street, Waipahu, Hawaii 96797	Inspection Date: April 10, 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
<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><u>FINDINGS</u> Substitute Care Giver (SCG) #1 and #2 – No documented evidence of a two-step (initial) tuberculosis clearance.</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>I obtained a copy of the 2 step TB test for SCG # 1 on 04/18/2024 and SCG #2 04/11/2024.</p>	04/21/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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><u>FINDINGS</u> Substitute Care Giver (SCG) #1 and #2 – No documented evidence of a two-step (initial) tuberculosis clearance.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>All residents, caregivers and family members must have a 2 step TB clearance documentation on file. I will check and review on the first month of each quarter and maintain a predetermined date of clearances in each resident's binder; PCG, SCG and family members in the care home binder. I will also write a note in my calendar every quarter to check clearances expiration date.</p>	07/18/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><u>FINDINGS</u> Resident #2 – No annual tuberculosis clearance.</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>I obtained a copy of the annual TB test of resident #2 on 04/17/2024.</p>	04/21/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports</u>, (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><u>FINDINGS</u> Resident #2 – No annual tuberculosis clearance.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I created a checklist of required documentation with expiration dates of each resident and placed post-it in the residents binder. I will review this checklist the first week of each month to ensure that I am reminded which one is expiring. I will review every three months the supporting documents to ensure that they are available in the binder. I will write a reminder in my calendar to prompt me to check.</p>	07/18/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(I) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either:</p> <p><u>FINDINGS</u> Three (3) non self preserving residents in home. Resident #2 – two out of three (2/3) forms completed on 3/30/2023 has resident designated as non self preserving.</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>I obtained a self preserving certification from the PCP on 4/11/2024. The PCP certified the resident as self preserving/ambulatory in the event of a disaster.</p>	07/18/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(I) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either:</p> <p><u>FINDINGS</u> Three (3) non self preserving residents in home. Resident #2 – two out of three (2/3) forms completed on 3/30/2023 has resident designated as non self preserving.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I will check and read all documents for the accuracy of what the PCP/any doctor had written prior to leaving the clinic.</p>	04/21/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (1) In addition to the requirements in subchapter 2 and 3:</p> <p>A registered nurse other than the licensee or primary care giver shall train and monitor primary care givers and substitutes in providing daily personal and specialized care to residents as needed to implement their care plan;</p> <p><u>FINDINGS</u> Resident #1 – No monitoring of primary care giver and substitutes who provide specialized care to resident (mid upper arm circumference measurements), as needed to implement the care plan. Recorded measurements as follows: 6/2023 = 27 cm 7/2023 = 25 cm 8-10/2023 = 29 cm 11/2023 = 26 cm</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>I reflected the MUAC of the resident in the DOH height & weight monthly record. (It was reflected on the other form [flow sheet] but failed to reflect on the DOH form).</p> <p>I requested the CM RN to provide me a training on how to measure MUAC.</p>	04/21/2024

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<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (1) In addition to the requirements in subchapter 2 and 3:</p> <p>A registered nurse other than the licensee or primary care giver shall train and monitor primary care givers and substitutes in providing daily personal and specialized care to residents as needed to implement their care plan;</p> <p><u>FINDINGS</u> Resident #1 – No monitoring of primary care giver and substitutes who provide specialized care to resident (mid upper arm circumference measurements), as needed to implement the care plan. Recorded measurements as follows: 6/2023 = 27 cm 7/2023 = 25 cm 8-10/2023 = 29 cm 11/2023 = 26 cm</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I will request CMRN to formulate a care plan and a training specific to a resident's diagnosis and needs during monthly visits or as needed.</p>	04/21/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (5) In addition to the requirements in subchapter 2 and 3:</p> <p>Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents.</p> <p><u>FINDINGS</u> SCG #3 – Nine out of twelve (9/12) continuing education hours completed within the last year. Please submit additional three (3) hours of continuing education with your plan of correction.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>SCG attended 4 continuing CEU.</p>	<p>04/21/2024</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (5) In addition to the requirements in subchapter 2 and 3:</p> <p>Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents.</p> <p><u>FINDINGS</u> SCG #3 – Nine out of twelve (9/12) continuing education hours completed within the last year. Please submit additional three (3) hours of continuing education with your plan of correction.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I will maintain a reminder that on the 30th of every month I will count how many CEUs had already been secured in the carehome binder. I will also review the dates of every single certificates issue date. I will remove the old certificates that does not fall on the current fiscal year of inspection.</p>	<p>04/21/2024</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services. (c)(4)</u> Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Update the care plan as changes occur in the expanded ARCH resident care needs, services and/or interventions;</p> <p><u>FINDINGS</u> Resident #1 – No care plan related to aspiration precautions including signs/symptoms, and interventions for resident diagnosed with dysphagia.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I discussed the issue with my case management (CM). She formulated a care plan specific to the resident's diagnosis of dysphagia. CM provided me a copy of the newly executed care plan. She also included a copy of aspiration precaution brochure for me to better understand.</p> <p>The care plan - aspiration precaution, S & S and intervention.</p>	<p>04/21/2024</p>

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Licensee's/Administrator's Signature: Marenila L Duran

Print Name: Marenila L Duran

Date: Apr 21, 2024

Licensee's/Administrator's Signature: Marenila L. Duran

Print Name: Marenila L Duran

Date: Jul 19, 2024