

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Maestro Care Home	CHAPTER 100.1
Address: 613 Hooahale Street, Pearl City, Hawaii 96782	Inspection Date: June 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
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p>FINDINGS Resident #1 – Physician order states, “Midodrine 2.5 mg take 1 tab po TD. Hold if SBP >140.” However, holding parameters not consistently being followed. April 2024 medication administration record (MAR) shows medication was held on numerous occasions despite BP of 138/95, 147/84, and 140/47; and medication was administered despite BP of 188/72.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><u>FINDINGS</u> Resident #1 – New medication order (prescribed on 2/7/24) of Ondansetron ODT 4 mg take 1 tab po Q 8hours PRN for nausea was not implemented on MAR until April 2024. The medication order was discontinued on 5/1/24.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-16 <u>Personal care services.</u> (h) A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed.</p> <p><u>FINDINGS</u> Resident #1 and Resident #2 – Plan of care and schedule of activities were not updated/revised to reflect current care/needs. For example, 0800-0900 schedule indicated E. M/walking, however, both residents are bedbound and wheelchair dependent. <i>Submit a copy of the revised Plan of Care with your plan of correction (POC).</i></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>Licensee updated the schedule of activities, adding a selection of activities that fits the resident's level of care ie: from ambulation to range of motion exercise in bed for the bed bound and wheelchair dependent.</p>	<p>06/06/2024</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-84 <u>Admission requirements.</u> (a) Licensees of an expanded ARCH shall admit nursing facility level residents as determined and certified by the resident's physician or APRN.</p> <p><u>FINDINGS</u> Resident #2 - level of care assessment completed on 3/16/24 indicates ARCH level of care. However, the resident has received case management services, is bedbound, and requires maximum assistance with ADLs. <i>Please have the resident's level of care reassessed by a physician and submit documentation with your POC.</i></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>PCG contacted the resident's PCP and requested to complete a reassessment for the resident using Level of care form. PCG received the completed form with appropriate resident's Level of care</p>	06/10/2024

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Licensee's/Administrator's Signature: *Amalia*

Print Name: Amalia Maestro RN

Date: 06/11/2024