Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: **The ARC in Hawaii Housing Proj. No. 11/Lusitana B**	**CHAPTER 89**
Address: 1660-B Lusitana Street, Honolulu, Hawaii 96813	**Inspection Date: November 13, 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.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-89-14 Resident health and safety standards. (e)(1) Medications: All medicines shall be properly and clearly labeled. The storage shall be in a staff-controlled work cabinet/work counter apart from either residents' bathrooms or bedrooms. **FINDINGS** Flonase 50mcg medication found unlabeled and unsecured in Bedroom #2 dresser. Home Manager removed the medication during inspection.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-89-14 Resident health and safety standards. (e)(5) Medications: All medications and supplements, such as vitamins, minerals, and formulas shall be made available by written physician order and shall be based upon current evaluation of the resident's condition. **FINDINGS** Resident #4 – There was no physician order for the Flonase 50mcg nasal spray found in his bedroom dresser.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-89-20 Resident accounts. (a) The conditions under which the caregiver agrees to be responsible for the residents' funds or property shall be explained and agreed to by the resident, or the guardian, and documented in the resident's file. **FINDINGS** Resident #1 – There was no signed financial statement available for review.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____