

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: The Plaza at Pearl City	CHAPTER 90
Address: 1048 Kuala Street, Pearl City, Hawaii 96782	Inspection Date: September 19 & 20, 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
<input checked="" type="checkbox"/>	<p>§11-90-8 <u>Range of services.</u> (a)(1) Service plan.</p> <p>The assisted living facility staff shall conduct a comprehensive assessment of each resident's needs, plan and implement responsive services, maintain and update resident records as needed, and periodically evaluate results of the plan. The plan shall reflect the assessed needs of the resident and resident choices, including resident's level of involvement; support principles of dignity, privacy, choice, individuality, independence, and home-like environment; and shall include significant others who participate in the delivery of services;</p> <p><u>FINDINGS</u> Resident #2 – Comprehensive assessment did not recognize hemodialysis treatment and the presence of LUE AVF. Records show resident is on scheduled hemodialysis Tuesday, Thursday, and Saturday and has LUE AVF. <i>Submit documentation of revised assessment 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>Admin and nursing leadership team met and discussed importance of capturing all information needed in the assessment.</p> <p>The director of nursing updated the comprehensive assessment to reflect hemodialysis on tues, thurs, sat in the specialists and other services section under dialysis treatment and noted presence of LUE AVF. The presence of LUE AVF is also added in the resident needs section under implants section.</p> <p>The administrator reviewed and confirmed that the comprehensive assessment was updated.</p>	<p>09/24/24</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-90-8 <u>Range of services.</u> (a)(2) Service plan.</p> <p>A service plan shall be developed and followed for each resident consistent with the resident's unique physical, psychological, and social needs, along with recognition of that resident's capabilities and preferences. The plan shall include a written description of what services will be provided, who will provide the services, when the services will be provided, how often services will be provided, and the expected outcome. Each resident shall actively participate in the development of the service plan to the extent possible;</p> <p><u>FINDINGS</u> Resident #2 – Current service plan did not include scheduled hemodialysis treatment and management of LUE AVF. <i>Submit documentation of revised service plan 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>The director of nursing updated the managed risk focus in the service plan to reflect hemodialysis treatment days of tues, thurs, sat.</p> <p>The director of nursing updated the managed risk focus in service plan to reflect the LUE AVF.</p> <p>The administrator reviewed and confirmed that the service plan was updated.</p>	09/24/24

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Licensee's/Administrator's Signature: *Dominique Hidaro*

Print Name: Dominique Hidaro

Date: 11/06/2024