Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Martha's	**CHAPTER 100.1**
Address: **516 Ihe Street, Honolulu, Hawaii 96817**	**Inspection Date: March 10, 2025 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
☒	§11-100.1-3 Licensing. (b)(1)(I) Application. In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application: Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law; **FINDINGS** House Hold Member (HHM) #1 & HHM #2 – No documented evidence that the house hold members have no prior felony or abuse convictions in a court of law on file for department review.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I make an appointment. It was done but it was rejected. It has to reschedule again. - Background was done. + it was file.	3/3/25 MT 6/23/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-3 Licensing. (b)(1)(I) Application. In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application: Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law; **FINDINGS** HHM #1 & HHM #2 – No documented evidence that the house hold members have no prior felony or abuse convictions in a court of law on file for department review.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** My future plan - make a list when it due and check. to make sure is done on time, Put on the record.	3/26/25 dt

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. **FINDINGS** HHM #1 & HHM #2 – No documented evidence of a current annual physical examination clearance from a physician or advanced practice registered nurse (APRN).	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - Appointment was made for 3/22/25 for a physical examination.	3/26/25 MT

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. **FINDINGS** HHM #1 & HHM #2 – No documented evidence of a current annual physical examination clearance from a physician or APRN.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** My future plan - make a note when it is due and put in my desk to remind me - double checked to make sure it is done. - Here is a copy of her physical clearance.	3/15/25 MT

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** HHM #1 & HHM #2 – No documented evidence of a current annual tuberculosis clearance from a physician or APRN.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I call the dialysis Dept. they sent me a copy of his TB clearance it was done on 2/10/25 read 2/12/25. It is on the record!	3/15/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** HHM #1 & HHM #2 – No documented evidence of a current annual tuberculosis clearance from a physician or APRN.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** My future plan – make a list when it is due. - Double check to make is sure done on time.	3/15/25 MT

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (i) 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. **FINDINGS** Resident #1 – No documented evidence of a current annual diet order from a physician or APRN.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** 9t was done on 3/15/25 together w her physical exam. It is on the record, the diet order is regular.	3/15/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (i) 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. **FINDINGS** Resident #1 – No documented evidence of a current annual diet order from a physician or APRN.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** My future plan - Make a list when is due to make sure is done on time & Double checked to make is done.	3/26/25 MT

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Health Care Provider ordered "Calcitriol 0.25mcg" capsule, "Cinacalcet 30mg" tablet, "Ciclesonide 160mcg/actuation" inhaler, "Guaifenesin 600mg" tablet, "Fluticasone 50mcg/actuation" nasal spray, "Hydrocortisone 2.5%" topical cream, and "Docusate sodium 10mmg" capsule on 11/5/2024. Aforementioned medications not available in facility for resident use.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I called the Dr office + we straight out the med. I got the new med order list. Here is the current med list.	11/14/25 MT

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Health Care Provider ordered "Calcitriol 0.25mcg" capsule, "Cinacalcet 30mg" tablet, "Ciclesonide 160mcg/actuation" inhaler, "Guaifenesin 600mg" tablet, "Fluticasone 50mcg/actuation" nasal spray, "Hydrocortisone 2.5%" topical cream, and "Docusate sodium 10mmg" capsule on 11/5/2024. Aforementioned medications not available in facility for resident use.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** My future plan – checks the med list + make sure old med to be removed from the list. My substitute care giver will double check to make sure it's there.	4/14/25 MT

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (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. **FINDINGS** Resident #1 – Resident #1 – Health Care Provider ordered "Calcitriol 0.25mcg" capsule, "Cinacalcet 30mg" tablet, "Ciclesonide 160mcg/actuation" inhaler, "Guaifenesin 600mg" tablet, "Fluticasone 50mcg/actuation" nasal spray, "Hydrocortisone 2.5%" topical cream, "Midodrine 5mg" tablet and "Docusate sodium 10mmg" capsule on 11/5/2024. Medication not documented on resident's medication administration record (MAR) from April 2024 to February 2025.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** My future plan – check w the ~~Doctor~~ MD order if it is current. If it is discontinue to make sure the med order is current + put in the flow sheet. - Double check the after visit paper if there is any changes make sure the flow sheet is change + sign.	3/26/25 MT

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (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. **FINDINGS** Resident #1 – Resident #1 – Health Care Provider ordered "Calcitriol 0.25mcg" capsule, "Cinacalcet 30mg" tablet, "Ciclesonide 160mcg/actuation" inhaler, "Guaifenesin 600mg" tablet, "Fluticasone 50mcg/actuation" nasal spray, "Hydrocortisone 2.5%" topical cream, "Midodrine 5mg" tablet and "Docusate sodium 10mmg" capsule on 11/5/2024. Medication not documented on resident's MAR from April 2024 to February 2025.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** My future plan - check med order list after Dr visit + make to discontinue and removed the med. Make the man and make sure the med is completed - Double check and chart right away in my absence or ear flier.	3/26/25 MT

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (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. **FINDINGS** Resident #1 – No documented evidence that the medication, "Midodrine 5mg" tablet, which was present in the facility, was either administered to, withheld, or refused by the resident from April 2024 to February 2025.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** My future plan: 1. Make sure med is given + sign chart on the flow sheet 2. Double check to make sure the medication is given + sign on the flow sheet. 3. I am very sorry. That med was given but I didn't sign for it. It won't happen again.	3/26/25. MT

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☒	§11-100.1-15 Medications. (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. **FINDINGS** Resident #1 – No documented evidence that the medication, "Midodrine 5mg" tablet, which was present in the facility, was either administered to, withheld, or refused by the resident from April 2024 to February 2025.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** My future plan – check the med bottle compair & my med flow sheet is the dose, same name and then give, + sign on the med sheet rightaway.	3/26/25 AL

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; **FINDINGS** Resident #1 – No documented evidence of a current annual physical examination clearance from a physician or APRN.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** 9t was done on 3/5/15. A copy of her physical exam is attached.	3/15/15 MT

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; **FINDINGS** Resident #1 – No documented evidence of a current annual physical examination clearance from a physician or APRN.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** My future plan - I will make a list when the physical is due - I will double check to make sure is done	2/16/25 MT

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; **FINDINGS** Resident #1 – No documented evidence of a current annual level of care evaluation from a physician or APRN.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** It was done on physical exam papers.	3/15/25 MT

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; **FINDINGS** Resident #1 – No documented evidence of a current annual level of care evaluation from a physician or APRN.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** My future plan: I will make a list on place in front of desk to remid me when is due. - I will double check to make sure is done on time.	3/16/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-23 Physical environment. (g)(3)(I) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: 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: **FINDINGS** Resident #1 – No documented evidence of a current annual self-preservation evaluation from a physician or APRN.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** It was done on the physical exam papers a copy is attached.	3/15/25 MT

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-23 Physical environment. (g)(3)(I) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: 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: **FINDINGS** Resident #1 – No documented evidence of a current annual self-preservation evaluation from a physician or APRN.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** It was done on 3/15/25. It was file on the record. My future plan make a list when is due and double check is done.	3/15/25 VH

Licensee's/Administrator's Signature: Maata Taumalolo

Print Name: Maata Taumalolo

Date: 3/28/25

Licensee's/Administrator's Signature: Marta Taumaloto

Print Name: MARTA Taumaloto

Date: 4/16/25