

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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| Facility's Name: Kalakaua Gardens | CHAPTER 90 |
| Address: 1723 Kalakaua Avenue, Honolulu, Hawaii 96826 | Inspection Date: June 25 & 26, 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. 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)(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 #1 – Physician order dated 6/9/25 reads, “Cefdinir 300mg po give 1 capsule twice a day for 7 days.” Per electronic medication administration record (eMAR), medication was started on 6/10/25 at 0800 and the last dose was given on 6/16/25 at 0800, missing one dose of antibiotic.</p> | <p>PART 1</p> <p>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>§11-90-8 <u>Range of services</u>. (a)(3) Service plan.</p> <p>The initial service plan shall be developed prior to the time the resident moves into the facility and shall be revised if needed within 30 days. The service plan shall be reviewed and updated by the facility, the resident, and others as designated by the resident at least annually or more often as needed;</p> <p><u>FINDINGS</u> Resident #3 – Admitted on 12/31/24, but the service plan was completed on 1/2/25, two days after admission.</p> | <p>PART 1</p> <p>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>§11-90-8 <u>Range of services.</u> (b)(1)(F) Services.</p> <p>The assisted living facility shall provide the following:</p> <p>Nursing assessment, health monitoring, and routine nursing tasks, including those which may be delegated to unlicensed assistive personnel by a currently licensed registered nurse under the provisions of the state Board of Nursing;</p> <p><u>FINDINGS</u> Resident #1 – Health monitoring was not provided throughout antibiotic treatment for UTI from 6/9/25-6/16/25.</p> | <p>PART 1</p> <p>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>§11-90-8 <u>Range of services</u>. (b)(3)(B)(ii) Services.</p> <p>The assisted living facility shall have policies and procedures relating to medications to include but not be limited to:</p> <p>Administration of medication:</p> <p>The facility shall provide and implement policies and procedures which assure that all medications administered by the facility are reviewed at least once every 90 days by a registered nurse or physician, and is in compliance with applicable state laws and administrative rules.</p> <p><u>FINDINGS</u> Resident #1 and #2 – Medication review was not timely completed between October 2024 and March 2025.</p> | <p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p> | |

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____