

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Village Park Adult Residential Care Home	CHAPTER 100.1
Address: 94-101 Kauweke Place, Waipahu, Hawaii 96797	Inspection Date: January 9, 2023 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
☒	§11-100.1-3 <u>Licensing</u>, (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; <u>FINDINGS</u> Primary Care Giver, Substitute Care Giver (SCG) #1, SCG #2, SCG #3 – No current documented evidence stating aforementioned care givers have no prior felony or abuse convictions in a court of law. Please provide a copy of your Fieldprint results with your plan of correction.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-3 <u>Licensing.</u> (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; <u>FINDINGS</u> Primary Care Giver, Substitute Care Giver (SCG) #1, SCG #2, SCG #3 – No current documented evidence stating aforementioned care givers have no prior felony or abuse convictions in a court of law. Please provide a copy of your Fieldprint results with your plan of correction.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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. <u>FINDINGS</u> Household Member #1 – No documented evidence of a current tuberculosis clearance from a physician or APRN. Please provide a copy of Tuberculosis clearance signed by a Physician or Advanced Practice Registered Nurse (APRN) with your plan of correction.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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. <u>FINDINGS</u> Household Member #1 – No documented evidence of a current tuberculosis clearance from a physician or APRN. Please provide a copy of Tuberculosis clearance signed by a Physician or Advanced Practice Registered Nurse (APRN) with your plan of correction.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; <u>FINDINGS</u> Substitute Care Giver #1 – No documented evidence of a current First Aid certification. Please provide a copy of First Aid certification with your plan of correction.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; <u>FINDINGS</u> Substitute Care Giver #1 – No documented evidence of a current First Aid certification. Please provide a copy of First Aid certification with your plan of correction.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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. <u>FINDINGS</u> Resident #1 – Physician order dated 5/24/22 for “Sulfacetamide 10% eye drops. Instill 1 drop into both eyes four times a day as needed.” No as needed (PRN) indication for aforementioned medications by Physician.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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. <u>FINDINGS</u> Resident #1 – Physician order dated 5/24/22 for “Sulfacetamide 10% eye drops. Instill 1 drop into both eyes four times a day as needed.” No as needed (PRN) indication for aforementioned medications by Physician.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(5) During residence, records shall include: Entries detailing all medications administered or made available; <u>FINDINGS</u> “Sulfacetamide 10% eye drops. Instill 1 drop into both eyes four times a day as needed” was ordered on 5/24/22. As needed (PRN) medication administered four times daily from 6/1/22 to 6/3/22 and twice on 6/4/22. No documented evidence of resident’s response to the as needed “PRN” medication.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(5) During residence, records shall include: Entries detailing all medications administered or made available; <u>FINDINGS</u> “Sulfacetamide 10% eye drops. Instill 1 drop into both eyes four times a day as needed” was ordered on 5/24/22. As needed (PRN) medication administered four times daily from 6/1/22 to 6/3/22 and twice on 6/4/22. No documented evidence of resident’s response to the as needed “PRN” medication.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN’T HAPPEN AGAIN?	

Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____