

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Sun Moon	CHAPTER 100.1
Address: 1020 Hala Drive, Honolulu, Hawaii 96817	Inspection Date: October 17, 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 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 <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; FINDINGS Household Member (HM) – No documented evidence stating that the HM living in the expanded ARCH have no prior felony or abuse convictions in a court of law. Please submit a copy of Fieldprint with your plan of correction.	PART I <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY <i>Talked to the household member, as she completed the background check as instructed. ^{ERAS} attach a copy of her finger Fieldprint.</i>	<i>1/10/25</i>

	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> HM – No documented evidence stating that the HM living in the expanded ARCH have no prior felony or abuse convictions in a court of law. Please submit a copy of Fieldprint 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? <i>In the future write a reminder note PCG, SCG, household member will get their background checks. put it in the couchone folder.</i>	<i>1/10/25</i>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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. <u>FINDINGS</u> HM – No documented evidence that the HM residing in the Type I ARCH have been examined by a physician to certify that they are free of infectious diseases. Please submit a copy of the Examination for Infectious Disease for Household Member and Non-direct Care Staff form with your plan of correction.	PART I <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY <i>Form about infectious diseases was given to the household member, completed physical exam was done & APRN certified it. Attach a copy of her certified P.E.</i>	<i>1/10/25</i>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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. <u>FINDINGS</u> HM - No documented evidence that the HM residing in the Type I ARCH have been examined by a physician to certify that they are free of infectious diseases. Please submit a copy of the Examination for Infectious Disease for Household Member and Non-direct Care Staff form 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? <i>In the future write a reminder note for all household members that they have their annual infectious disease certification. Put it in care home folder.</i>	<i>1/10/25</i>

	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. FINDINGS HM – No documented evidence of an initial and annual tuberculosis screening. Please submit a copy of the tuberculosis screening 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 <i>Household member had her tuberculosis screening. attach a copy of the TB screening</i>	<i>1/10/25</i>

	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> HM - No documented evidence of an initial and annual tuberculosis screening. Please submit a copy of the tuberculosis screening 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? <i>In the future, write a reminder note for PCG, SCG, HM residing in the ARCH have their annual TB screening. Post it in the care home folders.</i>	<i>1/10/25</i>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (h) All telephone and verbal orders for medication shall be recorded immediately on the physician's order sheet and written confirmation shall be obtained at the next physicians visit and not later than four months from the date of the verbal order for the medication. <u>FINDINGS</u> Resident #1 – No documented evidence of a written confirmation to continue Diltiazem 120 mg. Last confirmation for Diltiazem 120 mg was 3/5/24, and was not available on the physician orders written on 6/18/24.	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
☒	§11-100.1-15 <u>Medications</u>. (h) All telephone and verbal orders for medication shall be recorded immediately on the physician's order sheet and written confirmation shall be obtained at the next physicians visit and not later than four months from the date of the verbal order for the medication. FINDINGS Resident #1 - No documented evidence of a written confirmation to continue Diltiazem 120 mg. Last confirmation for Diltiazem 120 mg was 3/5/24, and was not available on the physician orders written on 6/18/24.	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? <i>In the future, make a master list of clients' medications and bring it with the client for the next physician visit, to get the physician confirmation. - Post it in the clubhouse folder as a reminder.</i>	1/10/25

Licensee's/Administrator's Signature: x Maria T G Gallego

Print Name: Maria T G Gallego

Date: Jan 13, 2025