

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

|  |   |
|--|---|
| Facility's Name: Sweet Haven                                 | CHAPTER 100.1                             |
| Address:<br>98-1274 Hoohuali Place, Pearl City, Hawaii 96782 | Inspection Date: December 12, 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 |
|-------------------------------------|---|--|-----------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications</u>. (g)<br/> All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year.</p> <p><b><u>FINDINGS</u></b><br/> Resident #1 - No documentation medication orders were reevaluated and signed by the physician every four months. <i>Submit documentation of the current signed medication orders with your plan of correction (POC).</i></p> | <p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>Resident Jones 12/25/20</i></p> |                 |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                                    |
|-------------------------------------|---|---|--|
| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications</u>. (g)<br/>All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year.</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 - No documentation medication orders were reevaluated and signed by the physician every four months. <i>Submit documentation of the current signed medication orders with your plan of correction (POC).</i></p> | <p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p style="text-align: center;"><i>In the future to avoid this deficiency a list of requirements that include 9 times reevaluation of medications a physician order should be posted in front of every chart.</i></p> | <p style="text-align: center;"><i>12/25/20</i></p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date                                  |
|-------------------------------------|---|--|--|
| <input checked="" type="checkbox"/> | <p>§11-100.1-19 <u>Resident accounts.</u> (a)<br/> The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative.</p> <p><b>FINDINGS</b><br/> Resident #2 and Resident #3 - No signed financial statement is recorded.<br/> <i>Submit a copy with your POC.</i></p> | <p style="text-align: center;">PART 1</p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>Signed copy of the<br/> report was obtained<br/> and filed under<br/> resident's financial<br/> statement.</i></p> | <p style="text-align: center;"><i>1/1/00</i></p> |

| RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date                                    |
|--|--|--|
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Licensee's/Administrator's Signature: [Handwritten Signature]

Print Name: [Handwritten Name]

Date: [Handwritten Date]

Licensee's/Administrator's Signature:

Amelia Legata

Print Name:

Amelia Legata

Date:

02/28/25