

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Yaying House Inc.	CHAPTER 100.1
Address: 3285 Olu Street, Honolulu, Hawaii 96816	Inspection Date: March 27, 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.

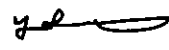
FAILURE TO CORRECT CITED DEFICIENCIES AS PER THE PLAN OF CORRECTION COULD RESULT IN REFUSAL TO RENEW YOUR LICENSE PER HAR 11-100.1-3(e)(3).

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. <u>FINDINGS</u> Resident #1 – Medication order for Timolol 0.5% eye drop = Instill 1 drop into right eye daily at 8:00 am. Medication label for Timolol 0.5% = Apply a small amount into right eye twice a day. Medication label does not accurately reflect medication order.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY Yes, I corrected the deficiency on 03/27/2025. Called Resident #1's eye doctor to inform the difference of physician order and medication label of Timolol 0.5% eyedrop, and requested MD to call pharmacy to get eyedrop with accurate label at 3pm on 03/27/2025. Picked up the new bottle of Timolol 0.5% eyedrop which match the Physician order around 5pm on 03/27/2025.	03/27/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. <u>FINDINGS</u> Resident #1 – Medication order for Timolol 0.5% eye drop = Instill 1 drop into right eye daily at 8:00 am. Medication label for Timolol 0.5% = Apply a small amount into right eye twice a day. Medication label does not accurately reflect medication order.	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? After getting medication from Pharmacy, I will check the medication label if it accurately reflect Physician order. If not match, I will call MD office to inform the difference and ask MD to call or fax the correct order right away. Do not wait for next visit to change label. Meanwhile, 1st day of each month, I need to check all the medication labels if match the all physician orders, Middle of each month, another staff to double check all the medication labels if accurately reflect physician orders. Hopefully, no more the same deficiency happened in the future. Thank you so much to point out for me.	04/02/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications</u>. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. <u>FINDINGS</u> Resident #1 – Medication order for Trazodone = 25 mg po qhs. Medication label for Trazodone = 50 mg – take ½ tablet by mouth at bedtime. May hold if too sleepy. Medication order does not include directions to hold the medication if the resident is too sleepy, as the medication label does.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY Yes, I corrected the deficiency in the afternoon on 03/27/2025. At 3:15pm, Called Resident #1 PCP regarding Medication label on Trazodone not the same as the Physician Order since the bottle shows " May hold if too sleepy" but the Physician Order has no "May hold if too sleepy", then took Physician Order paper to PCP office and MD corrected around 4pm.	03/27/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications</u>. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. <u>FINDINGS</u> Resident #1 – Medication order for Trazodone = 25 mg po qhs. Medication label for Trazodone = 50 mg – take ½ tablet by mouth at bedtime. May hold if too sleepy. Medication order does not include directions to hold the medication if the resident is too sleepy, as the medication label does.	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? In the future, I need to pay close attention to the medication label matching the Physician orders, after picking up every medication bottle, just check the physician order if the same. also at 1st day of each month and middle of each month, primary caregiver and one of staffs to check all the medication labels if the same as Physician Orders. hopefully no more the same mistake again. Mahalo to my nurse consultant.	04/02/2025

Licensee's/Administrator's Signature: 

Print Name: yaying liu

Date: Apr 2, 2025