

Office of Health Care Assurance

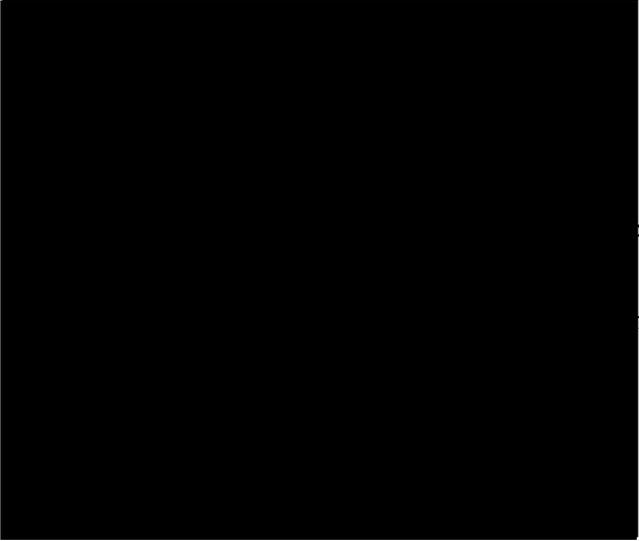
State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Aletha's Expanded ARCH	CHAPTER 100.1
Address: 99-631 Ulune Street, Aiea, Hawaii 96701	Inspection Date: March 18, 2015 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p><b>FINDINGS</b></p> <div style="background-color: black; width: 100%; height: 40px;"></div>	<p>IN The future I will thorough check the physical examination date given to substitute caregivers before letting her work as a primary care giver.</p>	4/24/2015
<input checked="" type="checkbox"/>	<p>§11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such</p>	<p>IN The future I will give necessary training for my substitute caregiver before allowing her work unattended and alone in the care home folder</p>	4/24/2015

	Rules (Criteria)	Plan of Correction	Completion Date
	<p>action.</p> <p><b>FINDINGS</b>  [REDACTED] no care giver training provided by [REDACTED]</p>		
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (i)  Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit.</p> <p><b>FINDINGS</b>  [REDACTED]</p>	<p>In the future I will write + file right away any telephone order made by Primary Care physician and bring to Doctor's office in doctor appointment to the doctor to sign.</p>	<p>4/24/2015</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-15 Medications. (e)  All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><b>FINDINGS</b>  [REDACTED]</p>	<p>In the future I'll should re check what I've written in my medication profile - check on Doctor's order and document it properly.</p>	<p>4/24/2015</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (f)</p>		

	Rules (Criteria)	Plan of Correction	Completion Date
	<p>Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><b>FINDINGS</b></p> 	<p>In the future I'll be very careful in writing on my medication all medication order upon discharge.</p>	<p>4/24/2015</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-17 Records and reports. (a)(3) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>Documentation of date of referral and admission, referral agency with address and telephone number, place or source from which admitted, physician, APRN, dentist, ophthalmologist, optometrist, psychiatrist, and all other</p>		

	Rules (Criteria)	Plan of Correction	Completion Date
	<p>medical or social service professionals who are currently treating the resident, next of kin, legal guardian, surrogate or other legally responsible agency;</p> <p><b>FINDINGS</b> Resident [redacted] current list of medications not listed on resident emergency information sheet.</p>	<p>In the future I need to frequently update medication currently taking or new orders come in to the emergency information sheet</p>	<p>4/24/2015</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p><b>FINDINGS</b> [redacted]</p>	<p>In the future I will <del>and</del> document and record the result of PRN medication especially of pain if had been relieved or not. and document + record whatever new unusual changes in cl's present situation.</p>	<p>4/24/2015</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(7) During residence, records shall include:</p> <p>Recording of resident's weight at least once a month, and</p>	<p>In the future I will record and document night away weight taken in every client in care home registry folder</p>	<p>4/24/2015</p>

	Rules (Criteria)	Plan of Correction	Completion Date
	<p>more often when requested by a physician, APRN or responsible agency;</p> <p><b>FINDINGS</b> Resident [redacted] no monthly weight recorded on height and monthly weight record [redacted]</p>		
<input checked="" type="checkbox"/>	<p>§11-100.1-17 Records and reports. (h)(1) Miscellaneous records:</p> <p>A permanent general register shall be maintained to record all admissions and discharges of residents;</p> <p><b>FINDINGS</b> [redacted]</p>	<p><i>IN The future once the client is out of the care home in hospital, I should discharge right away in the registry. and re-admit client upon arrival in the care home + document I used in the carehome registry</i></p>	<p><i>4/24/2015</i></p>

Licensee/Administrator's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

*4/24/2015*

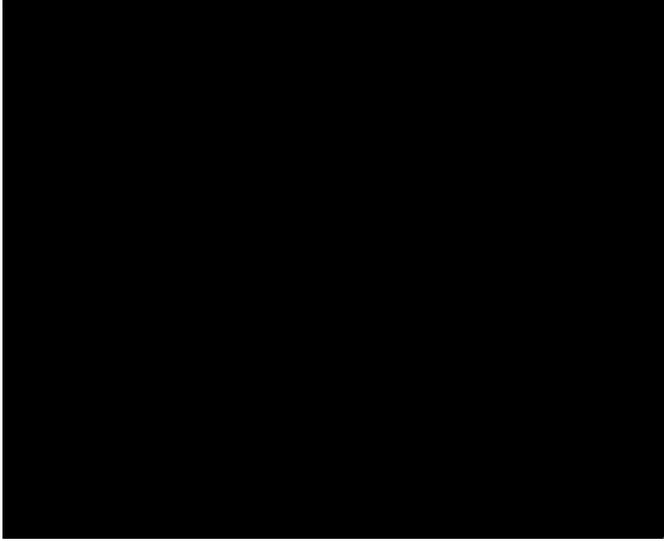
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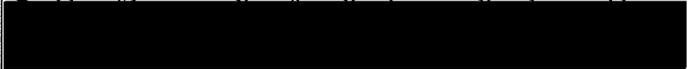
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<input checked="" type="checkbox"/>	<p>§11-100.1-17 Records and reports. (a)(3) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>Documentation of date of referral and admission, referral agency with address and telephone number, place or source from which admitted, physician, APRN, dentist,</p>		

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	<p>ophthalmologist, optometrist, psychiatrist, and all other medical or social service professionals who are currently treating the resident, next of kin, legal guardian, surrogate or other legally responsible agency;</p> <p><b>FINDINGS</b>  </p>	<p>after ms surveyor left I updated all my emergency information sheet</p>	<p>5/18/2015</p>
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Licensee/Administrator's Signature:

Print Name:

Date:

[REDACTED SIGNATURE AND NAME]

5 / 18 / 2015