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
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** [redacted]	IN The future I will thorough check the physical examination date given to Substitute Caregiver before letting her work as a Primary Care giver.	4/24/2015
☒	§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: Be trained by the primary care giver to make prescribed medications available to residents and properly record such	IN The future I will give necessary training for My Substitute Caregiver before allowing her Work document and file in the Care home folder	4/24/2015

	Rules (Criteria)	Plan of Correction	Completion Date
	action. **FINDINGS** [redacted]no care giver training provided by [redacted]		
☒	§11-100.1-13 Nutrition. (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. **FINDINGS** [redacted]	In the future I will write + file right away any telephone order made by Primary Care physician and bring to Doctor's office on Doctor appointment to the Doctor to sign.	4/24/2015
☒	§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. **FINDINGS** [redacted]	In the future I'll should re check what Rx written in my medication profile. Check on Doctors order and document it properly.	4/24/2015
☒	§11-100.1-15 Medications. (f)		

	Rules (Criteria)	Plan of Correction	Completion Date
	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. **FINDINGS** [redacted] by ne	in the future I'll be very carefull in writing on my medication all medication order upon discharge.	4/24/2015
☒	§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: 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		

	Rules (Criteria)	Plan of Correction	Completion Date
	medical or social service professionals who are currently treating the resident, next of kin, legal guardian, surrogate or other legally responsible agency; **FINDINGS** Resident [redacted] current list of medications not listed on resident emergency information sheet.	In the future I need to frequently update medication currently taking or new orders come in. to the emergency information sheet	4/24/2015
☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: 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; **FINDINGS** [redacted]	In the future I will ~~and~~ document and record the result of PRN medication especially if Pain ~~if~~ had been relieved or not. and document + record whatever new unusual changes in cl's present situation.	4/24/2015
☒	§11-100.1-17 Records and reports. (b)(7) During residence, records shall include: Recording of resident's weight at least once a month, and	In the future I will record and document right away weight taken in every Client in Call home registry folder	4/24/2015

	Rules (Criteria)	Plan of Correction	Completion Date
	more often when requested by a physician, APRN or responsible agency; **FINDINGS** Resident [redacted] no monthly weight recorded on height and monthly weight record [redacted]		
☒	§11-100.1-17 Records and reports. (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** [redacted]	IN The future once the client is out of the Care home in hospital, 2 should discharge right away on the registry. and re-admit client upon arrival in the Care home + document + record in the Care home registry	4/24/2015

Licensee/Administrator's Signature: [redacted]

Print Name: [redacted]

Date: 4/24/2015

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☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** [redacted]		
☒	§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: Be trained by the primary care giver to make prescribed medications available to residents and properly record such		

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-15 Medications. (f) 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. **FINDINGS** [redacted]	I should write away all medication ordered in my medication Profile upon discharge as soon Im home I should have / let my Substitute care giver double check on my MAR. after my Survey left I updated all my Emergency Information sheet	5/18/2015 5/18/2015 5/18/2015
☒	§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: Documentation of date of referral and admission, referral agency with address and telephone number, place or source from which admitted, physician, APRN, dentist,		

	Rules (Criteria)	Plan of Correction	Completion Date
	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; **FINDINGS** [redacted]	after my surveyor left I updated all my emergency information sheet	5/18/2015
☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: 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; **FINDINGS** [redacted]		
☒	§11-100.1-17 Records and reports. (b)(7) During residence, records shall include:		

	Rules (Criteria)	Plan of Correction	Completion Date
	Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency; **FINDINGS** Resident [redacted] no monthly weight recorded on height and monthly weight record for [redacted]		
☒	§11-100.1-17 Records and reports. (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** [redacted]		

Licensee/Administrator's Signature: [redacted]

Print Name: [redacted]

Date: 5/18/2015