

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Castro's (ARCH)	CHAPTER 100.1
Address: 3354 Eono Street, Lihue, Hawaii 96766	Inspection Date: March 11, 2016 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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 action.</p> <p><b>FINDINGS</b> Substitute care giver #1 No documentation of training by Primary Care Giver to make medications available and document such action.</p>	<p>Submitted copy of documentation of training for SCG #1 to FOC</p> <p>In the future I will train/teach my substitute caregiver and I will document training prior to inspection.</p>	4/1/16

	Rules (Criteria)	Plan of Correction	Completion Date
<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> Resident #1 [redacted] PRN given [redacted] [redacted] no documentation of response to medication.</p>	<p>On my monthly progress notes for resident #1, I will observe for any medication and behavior response.</p>	
	<p>When giving prn medication, I am documenting right away residents response to medication. I will go back and assess after one hour if medication is effective. In the future I will make a daily checklist or on a calendar to remind myself to go back and check on the monthly progress notes.</p>	<p>7/20/16</p>	
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(8) During residence, records shall include:</p> <p>Notation of visits and consultations made to resident by other professional personnel as requested by the resident or the resident's physician or APRN;</p> <p><b>FINDINGS</b> Resident #1 No progress note reflecting physician office visits [redacted]</p>	<p>For resident #1 there were progress notes for physician visits reflecting [redacted] [redacted] in the chart. I am submitting copy of above visit. In the future I will make sure that physician progress notes is available.</p>	<p>4/1/16</p>
		<p>Bring form to every doctor visits or ask for doctors notes after each visit. I am documenting on monthly progress after each doctor visit any orders or changes on their medications.</p>	<p>5/28/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
		<p>Upon giving prn medication, I am documenting right away resident's response to medication. If medication is effective. In the future I am documenting residents response to medication.</p>	<p>5/28/16</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (c)  Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary.</p> <p><b>FINDINGS</b>  Resident #1 No incident report for [redacted] emergency room visit.</p>	<p>I was aware of the emergency visit, but I forgot to make an incident report. I'm aware of each incident happen with my resident. I am using a calendar to remind me of each incident and I am checking the calendar every day to see if things to be done.</p>	<p>5/28/16</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (e)  In the event of an emergency, an oral summary of the resident's condition shall be provided to the receiving facility, followed by a written transfer summary.</p> <p><b>FINDINGS</b>  Resident #1 emergency information sheet does not list resident's current medications.</p>	<p>First when a new resident is admitted I need to prepare and make sure that emergency information sheet is complete. In the future, I need to fill out all information on the form, check it.</p> <p>Current medication list is complete and when there is changes on the medication I will remind myself by logging on the calendar.</p>	<p>7/20/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (f)(1) General rules regarding records:</p> <p>All entries in the resident's record shall be written in black ink, or typewritten, shall be legible, dated, and signed by the individual making the entry;</p> <p><b>FINDINGS</b> Resident #1 12/20/15 medication administration record has entries made in blue ink for [REDACTED]. [REDACTED] PRN.</p>	<p>It was an oversight, my <del>see</del> used blue ink when initialled on [REDACTED]. In the future I will use black ink per to initial medication record.</p>	<p>4/1/16</p>
		<p>I instructed my substitute caregiver to use my black ink on all documents, I removed all blue ink in the house.</p>	<p>5/28/16</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-20 <u>Resident health care standards.</u> (c) The primary and substitute care giver shall be able to recognize, record, and report to the resident's physician or APRN significant changes in the resident's health status including, but not limited to, convulsions, fever, sudden weakness, persistent or recurring headaches, voice changes, coughing, shortness of breath, changes in behavior, swelling limbs, abnormal bleeding, or persistent or recurring pain.</p> <p><b>FINDINGS</b> Resident #1 [REDACTED] No documentation of change in physical status reported to physician.</p>	<p>I will report to the doctor if there is any changes of weight every month. I will report to the doctor any wt. gain or loss wt. [REDACTED] in the future I will notify the doctor by phone to let him know the changes of my residents weight and I will document it to the monthly progress note that I notified the doctor.</p>	<p>7/20/16</p>

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☒	<p>§11-100.1-21 <u>Residents' and primary care givers' rights and responsibilities.</u> (a)(1)(C) Residents' rights and responsibilities:</p> <p>Written policies regarding the rights and responsibilities of residents during the stay in the Type I ARCH shall be established and a copy shall be provided to the resident and the resident's family, legal guardian, surrogate, sponsoring agency or representative payee, and to the public upon request. The Type I ARCH policies and procedures shall provide that each individual admitted shall:</p> <p>Be fully informed orally and in writing, prior to or at the time of admission, and during stay, of services available in or through the Type I ARCH and of related charges, including any charges for services not covered by the Type I ARCH's basic per diem rate;</p> <p><b>FINDINGS</b> Resident #1 general operating policy no specific rate for services rendered.</p>	<p>In the general operating policy I checked and updated with the current rates of services, I already placed a rate of service on the chart.</p>	<p>5/28/16.</p>

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

Print Name: Julie Castro

Date: 4/25/16

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

Print Name: Julie Castro

Date: 5/31/16

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

Print Name: Julie Castro

Date: 7/25/16