Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Ilar, Emelyn (ARCH/Expanded ARCH)	**CHAPTER 100.1**
Address: **1712 Keone Street, Hilo, Hawaii 96720**	**Inspection Date: August 26, 2015 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** Substitute care giver #1 no current tuberculosis (TB) clearance available. **PLEASE PROVIDE A COPY OF TB SKIN TEST WITH YOUR PLAN OF CORRECTION.**	Substitute #1 completely TB [redacted] I will use the calendar to remind me 30 days ahead of time when any residents substitute caregiver or myself is due physical & TB test and medical renewal. I will sign my substitute to also double check the calendar everymonth so that we do not missed the date.	5/4/16
☒	§11-100.1-15 Medications. (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.		

	Rules (Criteria)	Plan of Correction	Completion Date
	FINDINGS [redacted] Order and label do not match. **CLARIFY ORDER WITH PHYSICIAN.**	I called physician 4/12/16 to clarify the orders. The doctor call the pharmacy In the future I will clarify everything if it match the bottle & the order and I will teach my substitute to double check the medication if match or not. before we leave in the pharmacy.	5/4/16
☒	§11-100.1-15 Medications. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. **FINDINGS** 1. Resident #1 medication administration record (MAR) for [redacted] does not list instructions, [redacted]. 2. Resident #1 MAR for [redacted] does not list time for administration. [redacted]	1. [redacted] MAR was corrected. In the future I will read the instruction carefully as directed. I will train my substitute to double check on the MAR every month at the beginning of the month. 2. [redacted] I will train my substitute how to administered medication enlisted on the MAR. In the future I will & my substitute will list time of given. I will double check it daily if they list time of medication given.	5/4/16
☒	§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** Resident #1 no documentation in progress notes for the start and completion of [redacted], as well as the	Progress notes has been completed & do ument. In the future ~~when~~ I will do uments everything of the [redacted] in the progress note and I will document what is the effectiveness. And I will teach & tell my substitute how to documant of [redacted] and the effectiveness.	5/4/16

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	effectiveness of the treatment.		
☒	§11-100.1-17 Records and reports. (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. **FINDINGS** Resident #1 medications on the emergency data sheet incorrect. [redacted]	[redacted] was corrected. In the future I will change the emergency data when the doctor change the medication orders. Every three months I will let my substitute to double check my emergency data if there is a changed of data.	5/14/16
☒	§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** The general register shows Resident #2 as living in the home. Resident #2 was discharged [redacted].	I updated general register [redacted] to reflected registered # 2 discharged. In the future I will make two checklist one for admission & for discharge. The admission checklist will contain everything I need to complete admission resident including height & weight in general register admission physical, TB test on this change of checklist will remind me to do things to be prepared for admissions & discharge resident & also to be prepared for the annual inspection.	5/14/16

Licensee's/Administrator's Signature: Emelyn Ilar

Print Name: Emelyn Ilar

Date: 5/14/16