

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Apuya, Roger (ARCH)	CHAPTER 100.1
Address: 2517 Hoenui Street, Honolulu, Hawaii 96819	Inspection Date: July 5, 2016 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (c) Refrigerators shall be equipped with an appropriate thermometer and temperature shall be maintained at 45°F or lower.</p> <p><u>FINDINGS</u> No appropriate thermometer. Thermometer presented reflects 67 degrees Fahrenheit at room temperature.</p>	<i>please see attached</i>	
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p><u>FINDINGS</u> Resident #1 medication administration record does not reflect ordered [REDACTED]</p>	<i>please see attached</i>	

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(1) 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 primary care giver's assessment of resident upon admission;</p> <p>FINDINGS Resident #1 No primary care giver's assessment of resident upon admission.</p>	<p><i>please see attached</i></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>FINDINGS Resident #1 emergency information sheet reflects [REDACTED]</p>	<p><i>please see attached</i></p>	

Licensee's/Administrator's Signature: *Roger Apuya*

Print Name: ROGER APUYA

Date: 7/30/16

APUYA ADULT RESIDENTIAL CARE HOME
 2517 HOENUI ST.
 HONOLULU, HAWAII 96819

Rules (Criteria)	Plan of Correction	Completion Date
<p>11-100.1-14 Food Sanitation. (c) Refrigerators shall be equipped with an appropriate thermometer and temperature shall be maintained at 45 degrees Fahrenheit or lower.</p> <p>Findings: No appropriate thermometer. Thermometer presented reflects 67 degrees Fahrenheit at room temperature.</p>	<p>As soon as our Nurse consultant left for our annual inspection, I changed the old thermometer to a working thermometer right away.</p> <p>In the future, in order for me not to get the deficiency anymore, I have to check the thermometer every week and make sure that the reading should reflect the ideal temperature of 37 degrees Fahrenheit or refrigerator shall maintain 45 degrees Fahrenheit or lower for proper storage of food.</p> <p>If there is discrepancy on the thermometer reading, the thermometer has to be checked right away. In order to check if the thermometer is working properly, take out the thermometer outside and leave it on room temperature for 30 minutes to an hour and it should reflect room temperature reading if it's working properly. If not, then I have to purchase a new thermometer to replace the non-working device in order to ensure that thermometer is working properly.</p>	<p>July 5, 2016</p>

Rules (Criteria)	Plan of Correction	Completion Date
<p>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.</p> <p>Findings: Resident #1 medication administration record does not reflect ordered [REDACTED]</p>	<p>[REDACTED] I called Dr. [REDACTED] office and verified the proper dosage for [REDACTED]. As per telephone conversation with [REDACTED] confirmed that dosage is [REDACTED]. I transcribed it right away on the MAR and physician's record to reflect right dosage and upon resident's regular doctor's visit [REDACTED], I have to make sure that the physician signed the records (MAR & Physician Record) for proper documentation and filed on resident's binder.</p> <p>In the future, in order for me not to commit the same mistake again, whenever a physician order a new medication and before writing it on MAR, I have to make sure that name and dosage of medication match (from the order, medication bottle and MAR) and properly document it on MAR. If order is confusing, I have to call the doctor right away to verify the right medication/dosage and then transcribe order right away.</p> <p>(Please see attached)</p>	<p>July 6, 2016</p> <p>July 29, 2016</p>

Rules (Criteria)	Plan of Correction	Completion Date
<p>11-100.1-17 Records and Reports. (a)(1) 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 primary care giver's assessment of resident upon admission.</p> <p>Findings: Resident #1 No primary care giver's assessment of resident upon admission.</p>	<p>A new Admission Assessment/Care Plan was done [REDACTED] and filed it on resident's binder right away.</p> <p>I got the deficiency because client has been with us [REDACTED]. I know I made PCG Assessment /Care Plan but maybe when I thinned out [REDACTED] folder, I might have accidentally took it out.</p> <p>In order for me not to commit that mistake again, a checklist of the forms for resident's binder has to be made available and make sure that all of the required forms and paperworks are in the folder/binder and made available for the nurse consultant to review during the inspection. I also put a checklist copy on each resident's binder.</p> <p>An assessment can be done as soon as a resident is admitted or readmitted. If for some reasons, there are changes noted from the resident, a new assessment and care plan should be done and file it on resident's binder.</p> <p>(Please see attached)</p>	<p>July 6, 2016</p>

Rules (Criteria)	Plan of Correction	Completion Date
<p>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.</p> <p>Findings: Resident #1 emergency information sheet reflects [REDACTED] [REDACTED]</p>	<p>A new/updated Resident Emergency Information was done right after our nurse consultant left the home for inspection. [REDACTED] is now reflected on the Resident's Emergency Information.</p> <p>I usually update my resident's emergency information every beginning of the year and whenever there are changes on dosage/frequency of their medications [REDACTED]</p> <p>To prevent the deficiency from recurring, I have to make sure before printing out the form, I always have to double check all the dosage and frequency has to match from the physician's order and MAR for proper documentation and a correct information (in case of emergency) is available to be given to a receiving personnel/facility for review and proper continuing of care.</p> <p>(Please see attached)</p>	<p>July 5, 2016</p>