Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Villar, Marylin (ARCH)	**CHAPTER 100.1**
Address: **94-242 Pupukahi Street, Waipahu, Hawaii 96797**	**Inspection Date: December 14, 2015**

	Rules (Criteria)	**Plan of Correction**	**Completion Date**
☒	§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** Resident #1 – [redacted] ordered on [redacted]; the label reflected [redacted] The medication record reflected [redacted] Resident #1 – [redacted] ordered [redacted]; the [redacted] medication record reflected the following: [redacted] Resident #1 – [redacted]	[redacted] order was not clarified with the physician. [redacted] To prevents a similar deficiency – I will 8/25/15 make sure that the physician order matches with the bottle label and Resident's medication record. If not clarify w/ the physician. For [redacted] – I will make sure when I received physician order and then record it immediately to the Resident's medication record and double check that was was recorded with the 2nd physician order	

[redacted] ordered [redacted]; the [redacted] medication record reflected [redacted] was held on [redacted]; however, [redacted] given on [redacted].

Resident #1 – [redacted] ordered [redacted]; the [redacted] medication record reflected that no medication was given on [redacted].

Resident #1 – [redacted] ordered [redacted]; the medication record reflected [redacted] without a physician order. On [redacted] given; should have been [redacted].

Resident #1 – Clinic notes dated [redacted] listed the following [redacted] medications: [redacted]; however, the medications were not made available to the resident. There was no clarification with the physician.

I went to the doctors office to clarify the list of the ~~Medication~~ residents medications. [redacted]. To prevent similar deficiency – Before leaving physicians clinic I have to double check all medications that was listed. If I don't have order I have to verify w/ the doctor and get physicians order and prescription. 8/25/12

☒	§11-100.1-17 Records and reports. (a)(4) 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: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident #1 – No two-step tuberculosis clearance. A single step was given on [redacted] but read on [redacted].	TWO step TB skin test clearance completed. To prevent similar occurrences from occurring — I will check the date and the reading of the TB test. If the reading after three (3) days, [redacted] has to go back and re-do the single step.	8/25/14

☒	§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 – Progress notes did not reflect the resident's [redacted] diet ordered [redacted].	I did not document in my progress note the resident's intake of [redacted] diet. [redacted] To prevent similar date occurs - I will observe if resident's intake [redacted] food good or choking and document it in the Resident progress note monthly or as needed.	8/25/14
☒	§11-100.1-17 Records and reports. (b)(4) During residence, records shall include: Entries describing treatments and services rendered; **FINDINGS** Resident #1 – No documentation that the [redacted] ordered [redacted] was provided.	[redacted] diet shall be documented on the client record that was provided as ordered by the physician. In the future, I will make sure to document right away that I served [redacted] a [redacted] diet.	9/15/14

☒	§11-100.1-23 Physical environment. (g)(3)(A) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: Fire escapes, stairways and other exit equipment shall be maintained operational and in good repair and free of obstruction; **FINDINGS** There was an accordion door obstructing egress to the second [redacted] exit located at the back of the resident area.	accordion door obstructing egress mv ~~shall~~ always opened and follow the fire Department Policy. its already opened wide door for fire escapes and for free obstruction in case of emergency.	10/15/15 mv

Licensee's/Administrator's Signature: [signature]

Print Name: MARILIN VILLAR

Date: 3/8/16

Licensee's/Administrator's Signature: [signature]

Print Name: MARILIN VILLAR

Date: 6/7/16

Licensee's/Administrator's Signature: [signature]

Print Name: MARILIN VILLAR

Date: 7/1/16

Licensee's/Administrator's Signature: [signature]

Print Name: MARILIN VILLAR

Date: August 25, 2016