

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Weber's	CHAPTER 100.1
Address: 3056 Nihi Street, Honolulu, Hawaii 96819	Inspection Date: November 2, 2015 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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.</p> <p><b>FINDINGS</b> Household member #1 No current annual TB clearance.</p>	<p>see attached paper #1</p>	<p>8-5-2016</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.</p> <p><b>FINDINGS</b> [REDACTED] unsecured in resident accessible area.</p>	<p>All toxic, hazmat, cleaning agents are now and will remain <u>outside of resident accessible area</u> or in vault <u>under lock and key.</u></p>	<p>2/27/16</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no</p>		

	Rules (Criteria)	Plan of Correction	Completion Date
	<p>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.</p> <p><u>FINDINGS</u> Resident #1 [redacted] No label.</p>	<p><del>Resident #1</del> Corrective Action: resident's #1 [redacted] has been labeled as prescribed by MD. Future Plan: I will make sure that all medications or any over-the-counter medications shall be prescribed by the MD, and shall be verified and updated every MD visits.</p>	<p>11/2/15</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.</p> <p><u>FINDINGS</u> [redacted]</p>	<p>See attached paper # 2</p>	<p>8-5-2016</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><u>FINDINGS</u> Resident #1 No emergency information sheet that reflects current medications.</p>	<p>see attached paper # 3</p>	<p>8-5-2016</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>[redacted]</p> <p>when I take the monthly weight, when their client is [redacted] I report to the MD and document when gain or loss [redacted] when I take the monthly weight.</p>	<p>8-5-16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
	<p><b>FINDINGS</b>  [REDACTED] No documentation that change in physical status was communicated to physician.</p>	<p>See attached paper #4</p>	<p>8-6-2016</p>
<input checked="" type="checkbox"/>	<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>  [REDACTED]</p>	<p>If the sign agreement of the resident's does not have specific rate to charge I will not admit until it does.</p> <p>See attached paper #5</p>	<p>8-5-16</p> <p>8-6-2016</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-84 <u>Admission requirements.</u> (b)(4)  Upon admission of a resident, the expanded ARCH licensee shall have the following information:</p> <p>Evidence of current immunizations for pneumococcal and influenza as recommended by the ACIP; and a written care</p>	<p>I made a Flu shot checklist with the due date and check it every month so I will not forget the due date.</p>	

	Rules (Criteria)	Plan of Correction	Completion Date
	plan addressing resident problems and needs.  <u>FINDINGS</u> Resident #1 No current annual influenza vaccination.	<i>see attached paper # 6</i>	<i>8-6-2016</i>

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

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Licensee's/Administrator's Signature: Perla C. Weber

Print Name: PERLA C. WEBER

Date: NOV. 2, 2016

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Licensee's/Administrator's Signature: Perla C. Weber

Print Name: PERLA C. WEBER

Date: 2-27-16

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Licensee's/Administrator's Signature: Perla C. Weber

Print Name: PERLA C. WEBER

Date: 8-5-16

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Licensee's/Administrator's Signature: Perla C. Weber

Print Name: PERLA C. WEBER

Date: 8-6-2016

① Corrective Action: Household member #1 annual TB clearance is completed. PLS, see attached sheet.

Future Plan: I developed a checklist for all residents required annual TB clearance, Flu shot and Physical Exam. This checklist will be posted on my bulletin board for my daily reminders. PLS, see attached checklist.

Example: 2016

Resident #	Due date	Given date
Resident # 1 Flu shot TB clearance P.E.		
Resident # 2 Flu shot TB clearance P.E.		
Resident # 3 Flu TB clearance P.E.		
Resident # 4 Flu TB clearance P.E.		
Resident # 5 Flu TB clearance P.E.		
Family member # 1 Flu TB P.E.	10-20-2014	10-26-2015

② Corrective Actions:

expired date has been disposed wrapping all remaining with disposable pad and soaked it with water and dumped it into trash can.

Future Plan: I will ensure that all medications on over the counter medications shall be prescribed and reviewed every MD visits. all medications, or over the counter medications shall have label on it to specify issue date and expiration date and good for one year period. For example: labeled issued date of Aug. 1, 2016 will expire on Aug. 1, 2017, and after Aug. 1, 2017 medication shall be disposed. The medication expiration date shall be checked on a daily basis upon administering to my residents. Another way I will ensure that expiration date on all medications shall be highlighted and visible to reminded me when to disposed the medications or I will labeled it on the bottle itself.

③ Corrective Actions: Resident #1 current medication has been attached in Emergency Information sheet.

Future Plan: I made a separate binder for all my residents "Emergency Information Sheet". I named this binder "Webber's Emergency Information Binder." I made this binder for emergency purpose just in case I need to call for Ambulance, police, or Fire Dept. This binder has been separated with individual resident's name with a copy of health insurance, emergency information sheet and the current medication list signed by MD. I will ensure that a copy of most current medication listing will be placed on this binder! Anytime I will take my resident to MD for check up I will ensure that medications listing shall be updated and reviewed and signed by MD. The copy of this medication listing will be placed on this binder for emergency purposes.

④ Corrective action: I notified the MD for [REDACTED] weight and documented on my progress note.

Future Plan: In the future when the problem arise again to one of my resident's I should took action right away monitoring and documenting on my progress note food intake on a daily basis and weight resident on a weekly basis instead of monthly [REDACTED]



③ Corrective actions: I made memorandum for my clients monthly charges.

Future Plan: Please see attached sheet the example of "memorandum of agreement."

Example sheet:

From: \_\_\_\_\_

To: \_\_\_\_\_

Date \_\_\_\_\_

Subject: Monthly service of \$ \_\_\_\_\_  
the monthly charge will be \$ \_\_\_\_\_ including care supplies such as diapers, disposable pads, wipes, shampoo and soaps, shampoo. The family will responsible for personal expenses that is not included with the monthly payment.

⑥ Corrective actions: Made appointment to MD for my resident # Flu shot [redacted] and it was given.

Future Plan: I will make sure that all clients Flu shot shall be done annually, so as with the TB clearance and P.E. I developed a checklist for all the residents and family members and posted on my bulletin board for my reminder in daily basis. P.S. see the attached checklist example.

Example!

2010

Resident #1

Flu shot

TB clearance

P. Examination

Due date

n/d/4

Given date

n/d/4 10/12/2015

Resident #2

Flu shot

TB clearance

P. E

Resident #3

Flu shot

TB clearance

P. E

Resident #4

Flu shot

TB clearance

P. E

Resident #5

Flu shot

TB clearance

P. E

Family's reliever's

Flu shot

TB clearance

P. E