Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Analani ARCH, L.L.C.	**CHAPTER 100.1**
Address: **98-137 Kaluamoi Place, Pearl City, Hawaii 96782**	**Inspection Date: April 15, 2016 Annual**

	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 – the medication record reflected the medication was taken daily by the resident. Resident #1 – ordered without the dosage and frequency specified. Resident #1 – the medication record noted the medication was taken	A) THE ORDER TO STOP WAS RECEIVED UPON ADMISSION. TO PREVENT SIMILAR MISTAKES, I WILL ALWAYS CALL THE MD TO VERIFY THE ORDER BEFORE TRANSCRIBING IT TO THE MEDICATION FLOWSHEET. B) I CALLED THE PHYSICIAN & OBTAINED THE MEDICATION ORDER FOR , INCLUDING DOSAGE & FREQUENCY. TO PREVENT REPEATED MISTAKES, I WILL ALWAYS REVIEW THE PHYSICIAN'S ORDER FOR COMPLETENESS BEFORE TRANSCRIBING IT TO THE MEDICATION FLOWSHEET. I WILL ALWAYS ASK MY SUBS TO DOUBLE CHECK & MAKE SURE MEDICATION IS TRANSCRIBED PROPERLY. C) THE MEDICATION FLOWSHEET FOR ADMINISTERING WAS CHANGED TO PREVENT SIMILAR ERRORS, I WILL ALWAYS CHECK THE MEDICATION'S LABEL & FOLLOW THE PACKAGE INSERT INSTRUCTIONS BEFORE TRANSCRIBING. IF THERE ARE ANY INCONSISTENCIES, I WILL ALWAYS CALL THE MD FOR VERIFICATION.	OCTOBER 1, 2015 JANUARY 27, 2016 APRIL 16, 2016
☒	§11-100.1-15 Medications. (f) Medications made available to residents shall be recorded on		

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	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. **FINDINGS** Resident #1 – not reflected on the medication record.	I TRANSCRIBED THE MISSED ORDERS IN THE MEDICATION & TREATMENT RECORDS TO REFLECT THE PHYSICIANS ORDERS. MY SUBS WILL THOROUGHLY CHECK TO MAKE SURE NO MISTAKES WERE MADE.	OCTOBER 1, 2015
		IN THE FUTURE, ALL ORDERS WILL BE READ AND TRANSCRIBED CORRECTLY TO PREVENT ERROR. ADDITIONAL CARE GIVERS WILL CROSS-CHECK THE DATA TO CONFIRM NO ERRORS WERE MADE.	OCTOBER 1, 2015
☒	§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 at the time of admission.		
		IF THE SITUATION REOCCURS AND A RESIDENT LACKS A TWO-STEP TUBERCULOSIS CLEARANCE DURING THE TIME OF ADMISSION, CHEST X-RAY RESULTS SHALL THEN BE ATTAINED AS A SUBSTITUTION UNTIL THE 2ND STEP PPD IS COMPLETED. ANY QUESTIONS AND CONCERNS WILL BE DIRECTED TOWARDS THE NURSE CONSULTANT BEFORE TAKING ACTION.	OCTOBER 1, 2015
☒	§11-100.1-17 Records and reports. (a)(6) 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: Physician or APRN signed orders for diet, medications, and treatments;		

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	FINDINGS	I CHANGED THE TREATMENT RECORD TO CORRECTLY REFLECT THE MD'S ORDER. GOING FORWARD, I WILL MAKE SURE TO PROPERLY READ THE ORDER BEFORE & AFTER TRANSCRIPTION. I WILL ASK MY SUBS TO DOUBLE CHECK THAT THE MD'S ORDERS & TRANSCRIPTIONS MATCH.	OCTOBER 14, 2015
☒	§11-100.1-17 Records and reports. (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. **FINDINGS**	To prevent same mistakes, incident reports will be place in a care home binder, subs. caregiver have been trained + monthly check resident record & incident report not accidently filed in resident record folder.	APRIL 15, 2016 a/1c/16
☒	§11-100.1-17 Records and reports. (f)(2) General rules regarding records: Symbols and abbreviations may be used in recording entries only if a legend is provided to explain them; **FINDINGS** Resident #1 – No legend for initials used on the medication record.	THE PCG & SUBSTITUTES REVIEWED THE RECORDS & ADDED A LEGEND FOR INITIALS, SYMBOLS, & ABBREVIATIONS USED AND WILL CONTINUE TO BE CARRIED OUT IN EVERY RECORD CONSISTENTLY. THE LEGEND WILL BE USED TO FURTHER EXPLAIN THE SYMBOLS, INITIALS, OR ABBREVIATIONS. THIS IS TO AVOID ANY CONFUSION. EXAMPLE: (R) REFUSED (W) WITHHELD (H) HOME (NI) NOT GIVEN	APRIL 15, 2016
☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(1)(C) Residents' rights and responsibilities:		

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	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: 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; **FINDINGS** Resident #1 – No documentation that resident, resident's family were informed of the charges for services.	DOCUMENTATION WAS MADE & EXPLAINED TO THE FAMILY REGARDING THE CHARGES OF SERVICES & FEES OF THE RESIDENT. A COPY WAS PROVIDED TO THE FAMILY. IN THE FUTURE, I WILL ALWAYS MAKE SURE THAT A COPY OF CHARGES FOR SERVICES WILL BE PLACED IN THE RESIDENTS FOLDER & A COPY IS GIVEN TO THE RESIDENTS FAMILY.	APRIL 20, 2016 9/14/16

Licensee's/Administrator's Signature: _____

Print Name: CORAZON G. SALUDARES

Date: April 28, 2016

Licensee's/Administrator's Signature: _____

Print Name: CORAZON G. SALUDARES

Date: June 20, 2016

Licensee's/Administrator's Signature: _____

Print Name: CORAZON G. SALUDARES

Date: 8/03/2016

Licensee's/Administrator's Signature: _____

Print Name: CORAZON G. SALUDARES

Date: Sept. 08, 2016

Corazon g Saludares