

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Lusitana	CHAPTER 100.1
Address: 1925 Lusitana Street, Honolulu, Hawaii 96813	Inspection Date: September 9, 2016 Annual

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

RECEIVED
16 OCT -3 AM 1:45
STATE OF HAWAII
HHS-ORCA LICENSING

	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><u>FINDINGS</u> PCG no evidence of annual tuberculosis screening. Please submit evidence of annual tuberculosis screening with your plan of correction.</p>	<p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>TB screening was done during my annual physical exam, but the right TB clearance form wasn't signed by the MD.</i></p> <p><i>I went back to the MD's clearance office to get the right TB form signed by the MD.</i></p>	<p><i>Yes</i></p> <p><i>9/14/16</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-9(b)	<p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>In the future, I will make a checklist of the forms needed to be signed by the MD during the physical exam. Also, I will prepare a packet of the forms ready to bring for the physical exam.</i></p>	<p style="text-align: center;"><i>9/14/16</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(6) During residence, records shall include:</p> <p>All recordings of temperature, pulse, respiration as ordered by a physician, APRN or as may appear to be needed. Physician or APRN shall be advised of any changes in physical or mental status promptly;</p> <p><u>FINDINGS</u> Resident #1 no vital signs performed week of September 2, 2016.</p>	<p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Yes</i></p> <p><i>Resident #1 vital signs were 9/09/16 taken / performed on the week of September 2, 2016, however, they weren't recorded.</i></p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	RULE # §11-100.1-17(b)(6)	<p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>In the future, I will record/document the residents vital signs right after they were taken/performed.</p> <p>I will ask Adv^{CP} all my substitute caregivers to remind me to document/record right after performing the patient's vital signs, and to double check the residents chart to make sure that the vital signs are properly recorded/documentated.</p>	9/09/16

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(3) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Review the care plan monthly, or sooner as appropriate;</p> <p><u>FINDINGS</u> Resident #1 nursing care plan not updated/reviewed by case manager since February 2016.</p>	<p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Discussed this deficiency with the RNCM of the agency. Apparently, there has been changes in the visiting nurses. The care plan was actually reviewed monthly, however, the date of the review was not written on the care plan.</i></p>	<p><i>Yes</i> <i>9/9/16</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-88(c)(3)	<p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"> <i>In the future, I will flag the care plan and any other documents for the RNCM to review to remind me to address with the RNCM. It will be flagged using past it notes. And before the RNCM leaves the care home, I will double check the the care plan, see to it that it's dated & initialed by the RNCM.</i> </p>	<i>9/9/16</i>

Licensee's/Administrator's Signature: Carolyn De Guzman

Print Name: CAROLYN DE GUZMAN

Date: 9/27/2016