

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Guerrero, Miriam (ARCH)	CHAPTER 100.1
Address: 66 Kaiwiki Road, Hilo, Hawaii 96720	Inspection Date: February 15, 2017 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.

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p>FINDINGS Substitute care giver (SCG) #1, no physical examination. This is a repeat deficiency from your 2016 annual inspection.</p>	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>made an appointment for P.E. on April 5/17</i></p>	<p style="text-align: center;"><i>4/5/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
☒	RULE # §11-100.1-9 (a)	<p style="text-align: center;">PART 2 <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>Mark on calendar the expiration date of P.E. & make an appointment one or two months prior & remind him to get on his calendar as well. Made a reminder list of all substitutes & myself the expiration date & check notes once a month.</p>	Feb. 28/17

	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> SCG #1, no tuberculosis (TB) clearance. This is a repeat deficiency from your 2016 annual inspection.</p>	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>made an appointment to do X-ray on March 10, 17</i></p>	<p style="text-align: center;"><i>3/10/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
☒	RULE # §11-100.1-9 (b)	<p style="text-align: center;">PART 2 <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>Mark on calendar the expiration date for tb clearance & on to two months prior make an appointment to do tb clearance at the same time w/ P.E. Made a reminder list of all substitutes & myself the expiration date & check notes once a month</p>	Feb. 28/17

	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> One (1) refrigerator was equipped with an oven thermometer.</p>	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>It was replaced to a refrigerator thermometer.</i></p>	<p><i>Feb. 16 / 17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>RULE # §11-100.1-14 (c)</p> <p><u>FINDINGS</u> One (1) refrigerator was equipped with an oven thermometer.</p>	<p align="center">PART 2 <u>FUTURE PLAN</u></p> <p align="center">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Check every so often that refrigerator is surely equipped w/ a thermometer, check once a month or more often & put thermometer that when you open you can see it right away</p>	<p align="right">Feb. 28/17</p>

	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> One (1) refrigerator not equipped with a refrigerator thermometer.</p>	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>I bought a refrigerator thermometer</i></p>	<p style="text-align: center;"><i>Feb. 16/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>RULE # §11-100.1-14 (c)</p> <p><u>FINDINGS</u> One (1) refrigerator not equipped with a refrigerator thermometer.</p>	<p>PART 2 <u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Post a note on refrigerator to check if there's a thermometer. Check every 50 opens & put it in a place that you I can see right away when I open. Make sure it's below 45 degrees</p>	<p>Feb. 28/17</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u></p> <p>1) Resident #1, physician order dated September 20, 2016 read the following:</p> <ul style="list-style-type: none"> • “clobetasol 0.05% Topical Soln apply by topical route 2 times every day to the affected scalp area in the morning and evening.” • “Flonase 50 mcg/Actuation Nasal Spray, spray 1 spray by intranasal route every day in each nostril.” <p>However, both medications were not listed on the September 2016 – January 2017 medication records.</p>	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>I called Bay Clinic & according to the nurse these two medications are inactive but for proper documentation Dr. is coming back on Thursday (Feb 2) & they will give me a call to fix this matter. Follow up w/ doctor & obtain a delglone order.</i></p>	<p style="text-align: right;"><i>Feb. 28/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>RULE # §11-100.1-15 (e)</p> <p><u>FINDINGS</u> Resident #1, physician order dated September 20, 2016 read the following:</p> <ul style="list-style-type: none"> • “clobetasol 0.05% Topical Soln apply by topical route 2 times every day to the affected scalp area in the morning and evening.” • “Flonase 50 mcg/Actuation Nasal Spray, spray 1 spray by intranasal route every day in each nostril.” <p>However, both medications were not listed on the September 2016 – January 2017 medication records.</p>	<p align="center">PART 2 FUTURE PLAN</p> <p align="center">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will always check that on doctor's visits, I let the doctor sign the MAR to make sure that all medications are updated & I always match orders w/ my MAR when documenting.</i></p>	<p align="center"><i>Feb. 28 / 17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u></p> <p>2) Resident #1, physician order dated September 20, 2016 read, “CVS Acetaminophen ER 650 mg Take 1 tablet by mouth every <u>8</u> hours as needed for pain.” However, September – December 2016 medication record read, “Tylenol 650 mg 1 every <u>6</u> hrs. PRN.”</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

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<input checked="" type="checkbox"/>	<p>RULE # §11-100.1-15 (e)</p> <p><u>FINDINGS</u> Resident #1, physician order dated September 20, 2016 read, "CVS Acetaminophen ER 650 mg Take 1 tablet by mouth every 8 hours as needed for pain." However, September – December 2016 medication record read, "Tylenol 650 mg 1 every 6 hrs. PRN."</p>	<p>PART 2 <u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>At the start of the month - Always match Physician's orders + medication bottle when I document on my MAR. Write on notes (reminders)</i></p>	<p><i>Feb. 28/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>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;</p> <p><u>FINDINGS</u> Resident #1, February 2016 – February 2017 monthly progress notes did not document the response to prn "Hydrocortisone 2.5% lotion" administered twice daily.</p>	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Starting February, I document on progress notes the response to PRN medication Hydrocortisone 2.5% lotion that is being administered BID</i></p>	<p><i>Feb. 28/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-17 (b)(3)	<p style="text-align: center;"> PART 2 <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> <i>Read on Instructions for Progress notes whenever I do my monthly progress notes so that I will not miss anything that's needed to be documented</i> </p>	<i>Feb. 28/17</i>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(G) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Smoke detectors shall be provided in accordance with the most current edition of the National Fire Protection Association (NFPA) Standard 101 Life Safety Code, One and Two Family Dwellings. Existing Type I ARCHs may continue to use battery operated individual smoke detector units, however, upon transfer of ownership or primary care giver, such units shall be replaced with an automatic hard wiring UL approved smoke detector system;</p> <p><u>FINDINGS</u> No monthly smoke detector checks for October 2016 – January 2017.</p>	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

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<input checked="" type="checkbox"/>	RULE # §11-100.1-23 (g)(3)(G)	<p style="text-align: center;"> PART 2 <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> <i>Put on cell phone - alert warning sound to remind me the day of every month to check smoke detector</i> </p>	<i>Feb. 16/17</i>

Licensee's/Administrator's Signature: Miriam S. Guerrero

Print Name: MIRIAM S. GUERRERO

Date: Feb. 28 / 17