Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Fiesta, Johnny (ARCH)	**CHAPTER 100.1**
Address: **1411 Gulick Avenue, Honolulu, Hawaii 96819**	**Inspection Date: April 11, 2016 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; **FINDINGS** Substitute care giver (SCG) #1, no current first aid certification.	SEE ATTACHED	4/20/16
☒	§11-100.1-10 Admission policies. (a) Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be obtained prior to a resident's admission to a Type I ARCH and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's		5/24/16

	Rules (Criteria)	Plan of Correction	Completion Date
	responsible placement agency, and others authorized by the resident to review it. **FINDINGS** Resident #1, admitted on March 1, 2016, no level of care assessment completed by a physician or APRN.	SEE ATTACHED	4/20/16
☒	§11-100.1-13 Nutrition. (a) The Type I ARCH shall provide each resident with an appetizing, nourishing, well-balanced diet that meets the daily nutritional needs and diet order prescribed by state and national dietary guidelines. To promote a social environment, residents, primary care givers and the primary care giver's family members residing in the Type I ARCH shall be encouraged to sit together at meal times. The same quality of foods provided to the primary care givers and their family members shall be made available to the residents unless contraindicated by the resident's physician or APRN, resident's preference or resident's family. **FINDINGS** No documented menu substitutions.	SEE ATTACHED	5/24/16 4/20/16 5/24/16
☒	§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** 1) Resident #1, physician order dated, March 16, 2016 read, "Depakote 125 mg PO BID." However, April 2016 medication record read, "Divalproex 125 mg, 1-tab AM." 2) Resident #1, physician order dated, March 29, 2016	SEE ATTACHED	4/20/16

	Rules (Criteria)	Plan of Correction	Completion Date
	read, "Tylenol 500 mg 1-2 tab QID po x 1 month." However, number of tabs administered was not documented on March and April 2016 medication records.		
☒	§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; **FINDINGS** Resident #1, admitted on March 1, 2016, March and April 2016 medication records read, "Loratadine 10 mg 1 tab daily." However, no physician order.	SEE ATTACHED	4/20/16 5/24/16
☒	§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, March and April 2016 monthly progress notes, no response to prn Tylenol 500 mg 1-2 tabs po QID.	SEE ATTACHED	4/20/16 5/24/16

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-17 Records and reports. (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** Resident #2, discharge date not documented on the permanent general register.	SEA ATTACHED	4/20/16 5/24/16

Licensee's/Administrator's Signature: Johnny M. Fiesta

Print Name: JOHNNY M. FIESTA

Date: 4/20/2016

Licensee's/Administrator's Signature: Johnny Fiesta

Print Name: JOHNNY FIESTA

Date: MAY 24, 2016

Attachment May 24, 2016

11-100.1-9 SC#1- First aid completed on April 20, 2016 & filed in Fiesta ARCH record.

CG will document on a spread sheet (calendar) when all SCs first aid, CPR, PE & TB due dates. CG will check every quarter & remind SCs of expiration date. One month before the inspection date, CG will check to see if all documents are in the CG record.

11-100.1-10: Resident #1- primary doctor completed level of care 04/20/16.

11-100.10 Before admitting new resident CG to use admission check list to make sure all required documents in admission are available.

11-100.1-13: Corrected. Made a daily menu substitution. When well balanced daily menu can't be followed, a substitute menu should be available. There needs to be sure there is the 4 food group- meat, vegetables, fruits, and milk.

11-100.1-13 Menu substitutions are documented on a calendar & located on the kitchen cabinet wall in front of the refrigerator. CG will document the food that is substituted.

11.100. 1-15: Corrected for Resident 1 on April 11, 2016 on medication record and wrote Divalproex 125 PO BID. Carefully looked at physician order and write it on medication record carefully checking the name, dosage, and frequency especially when writing for the next month. Check the order against the medication record each time resident sees the doctor.
Corrected for Resident 1 on medication record on April 11, 2016 to start writing 1 or 2 next to the time with my initial. In the future if doctor orders 1-2 medication, CG needs to make sure it is documented if given 1 tablet or 2 tablets next to the time given and initial.

11-100. 1-17(a) Corrected for Resident #1. Got order for Loratadine 10 mg 1 tablet daily by doctor on 4/21/16.
When resident is being admitted to another ARCH, physician order form needs to be filled with all resident's medications that are to be continued and transcribed in the medication record. Also to be checked after all doctor visits.

When admitting a resident from another care home, CG will make sure that all medication bottle labels matches with physician order. If the resident with a medication that is not on the physician order, call the previous CG to see if there is an order. If no order, CG will hold medication & call physician to get a telephone order for resident to use the medication.

11-100.1-17(b) Correction for Resident #1 started April 11,2016. Wrote the response of the Tylenol and Guifenesin on the progress note. In the future, all PRN Medications needs to be charted on progress note the response of the resident.

On the first day of the month, CG will document on the progress note reviewing the previous month on the medications that are prn of the response of the resident.

11-100. 1-17: Resident #2- discharged date documented on the permanent general register. When a resident is being discharged from the Fiesta ARCH, the date and all that is requested needs to be written on the permanent general register.

SC will document the residents discharge date on the general registry on the same day of the resident discharge from the care home.