

Office of Health Care Assurance

State Licensing Section

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: RC Golfview ARCH	CHAPTER 100.1
Address: 1316 Ala Puaala Way, Honolulu, Hawaii 96818	Inspection Date: November 22, 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.**

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	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 ARCII shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><u>FINDINGS</u>                      Substitute care giver #1 tuberculosis screen attestation completed by not dated by APRN.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>On 11/23/16, substitute Caregiver #1 returned to doctors office w/ original form filled previously to obtain &amp; filled the missing date. It was initiated by APRN. Annual TB screen attestation was completed on 4/27/16 but not dated. Annual physical was done at same date &amp; time w/ the same MD.</p>	<p style="text-align: center;">11/23/16</p> <p style="text-align: center;"><i>[Signature]</i></p> <p style="text-align: right; font-size: small;">RECEIVED                      DEC 12 2016</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE #11-100.1-9(b)	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>In the future, It is my responsibility as PCG to review all forms when completed are signed &amp; dated where needed. To prevent any future occurrence, I need to remind all caregivers that any documents filled must have signature &amp; dated accordingly to be valid.</i></p>	<p style="text-align: right;"><i>11/23/16</i></p> <p style="text-align: right;"><i>Proble</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<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 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 physician orders dated 10/31/16 and 11/7/16 read, "Miralex 17 grams mixed with 8 oz. of liquid by mouth daily. Hold for loose stool." Label on bottle reads, "17 grams with 4-8 oz. of liquid daily <u>PRN</u>, hold for loose stools." Orders and label do not match.</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;"><i>I called the doctors office to point out the mismatch of order &amp; label of Miramax medication. the doctors office called pharmacy for new prescription to reflect current order. the new label now match the physicians order.</i></p>	<p style="text-align: right;"><i>12/24/16</i></p> <p style="text-align: right;"><i>[Signature]</i></p> <p style="text-align: right;">RECEIVED OFFICE OF THE STATE COMMISSIONER OF HEALTH SERVICES 16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE #11-100.1-15(a)	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>In the future, it is my job or any substitute that pick up medication from pharmacy to bring a copy for order to make sure the label on medication picked up matches the order prescribed by physician.</i></p>	<p style="text-align: center;"><i>11/24/16</i></p> <p style="text-align: right; font-size: small;">             RECEIVED              OF 1 16              RECEIVED              11/24/16           </p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-16 <u>Personal care services.</u> (h)  A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed.</p> <p><b>FINDINGS</b>  Resident #1 no schedule of activity posted or in chart.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>An activity schedule for Resident #1 was made and placed in chart for resident to follow + quote to daily activities.</i></p>	<p style="text-align: right;"><i>11/26/16</i></p> <p style="text-align: right; font-size: small;">RECEIVED  DEC 12 2016</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE #11-100.1-16(h)	<p style="text-align: center;">PART 2</p> <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, use a checklist to make sure all forms are completed for resident admissions. Have secondary caregivers review the forms also to make sure all forms in checklist is completed properly. Always good to have a secondary caregiver double check chart when completed to make sure checklist is complete.</p>	<p style="text-align: right;">11/26/16</p>

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	Rules (Criteria)	Plan of Correction	Completion Date
<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><b>FINDINGS</b>            Resident #1 emergency data sheet medication list not updated with new doses and medication.</p>	<p>PART 1</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Updated emergency data sheet list with current medications &amp; doses. These list of medication must be the same as meds in MAR.</i></p>	<p><i>11/24/16</i></p> <p>REC'D MED</p>



	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE #11-100.1-17(e)	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>In the future, to ensure that it doesn't happen again, whenever there is new meds or changes in meds, the emergency data sheet must also be updated. This sheet must be included in checklist to be updated as soon as there is necessary changes. A date in calendar must be noted to check &amp; update list every month or as soon as changes in doctors order as given.</i></p>	<p style="text-align: center;"><b>11/26/16</b></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (5) In addition to the requirements in subchapter 2 and 3:</p> <p>Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents.</p> <p><b>FINDINGS</b> Substitute care giver #2 short three (3) continuing education hours. Please submit three (3) additional CEU's with your plan of correction.</p>	<p>PART 1</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>Substitute Caregiver # 2 has completed 3 Continuing education hours needed to complete 12 hours needed annually for ARCH + expanded ARCH.</i></p> <p><i>Certificate is included..</i></p>	<p>12/9/2016</p> <p>RECEIVED DIVISION OF LICENSING 16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE #11-100.1-83(5)	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>In the future, I, the PCG, have to check that all CEUs taken are pertinent to nurses and care. All 12 CEUs must be patient care related or secondary caregivers. Use calendar to schedule CEUs throughout the year to make sure proper amount of credits are completed.</i></p>	<p style="text-align: right;"><i>12/9/2016</i></p>

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Licensee's/Administrator's Signature: Romulo Romeo Cardenas  
 Print Name: Romulo Romeo Cardenas  
 Date: 12/12/16

STATE OF TEXAS  
 DEPARTMENT OF LICENSING

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