

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name: Josephine Cabal (ARCH/Expanded ARCH)</b>	<b>CHAPTER 100.1</b>
<b>Address: 2322 Awapuhi Street #1, Hilo, Hawaii 96720</b>	<b>Inspection Date: May 17, 2017 Annual</b>

**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><u>FINDINGS</u>  Household member (HM) #1, no physical examination.</p>	<p style="text-align: center;">PART 1</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>YES, APPOINTMENT HAS BEEN SCHEDULED FOR 8/31/17. PRIMARY PHYSICIAN WILL BE ON VACATION. HOUSEHOLD MEMBER WAS RESTRICTED FROM CONTACT WITH RESIDENTS, UNTIL APPOINTMENT COMPLETED.</p>	<p style="text-align: right;">8/31/17</p>

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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 ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><b><u>FINDINGS</u></b> Primary care giver (PCG), tuberculosis (TB) skin test administered on April 17, 2017 initialed as read – “0 mm.” However, no date of reading.</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>YES, IT IS CORRECTED NURSE READING THE RESULTS FORGOT TO DATE. NURSE REVIEWED RECORDS AND CORRECT DATE WAS DOCUMENTED. (CORRECT "READ" DATE)</p>	<p style="text-align: right;">8/30/17</p>

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<input checked="" type="checkbox"/> §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.  <u>FINDINGS</u> HM #1, no TB clearance.	<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 style="text-align: center;"><i>HM #1 USUALLY HAS FALSE POSITIVE TB TESTS. PROPER DOCUMENTATION OBTAINED AND CLEARED BY PRIMARY PHYSICIAN.</i></p>	<p style="text-align: center;"><i>8/18/17</i></p>

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	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><b><u>FINDINGS</u></b> Resident #1, April 2017 medication record read, "Dorzolamide HCl - Timolol Cef 1 drop in each eye BID - d/c 4/29." However, no physician order to discontinue the medication.</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>YES, CLARIFICATION ORDER OBTAINED FROM M.D. - M.D. ORDERED CONTINUATION OF MED, ALTHOUGH LABEL READS DIC 4/29.</p>	<p style="text-align: center;">8/18/17</p>



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	Rules (Criteria)	Plan of Correction	Completion Date
☒	<p>§11-100.1-15 <u>Medications</u>. (m)  All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver.</p> <p><b><u>FINDINGS</u></b>  Resident #1, physician order of April 11, 2017 read, "Novolog Flex Pen Insulin three times a day AC by sliding scale (FBS &lt;199 = 0; 200-249 = 3 units; 249-300 = 5 units; 300-349 = 7 units; 350-400 = 10 units &gt;400 = 10 units)." However, April and May 2017 medication record did not indicate the following:</p> <ul style="list-style-type: none"> <li>• Number of Novolog units administered per sliding scale</li> <li>• Administration site</li> </ul>	<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 style="text-align: center;"><i>YES, THE MEDICATION ADMINISTRATION SHEET HAS BEEN REDDNE TO INCLUDE NUMBER OF UNITS GIVEN PER SLIDING SCALE AT ADMINISTRATION SITE.</i></p>	<p style="text-align: center;"><b>Completion Date</b></p> <p style="text-align: center;"><i>8/18/17</i></p>

Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/> §11-100.1-15 <u>Medications</u> . (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver.  <b><u>FINDINGS</u></b> Resident #1, physician order of April 11, 2017 read, "Novolog Flex Pen Insulin three times a day AC by sliding scale (FBS <199 = 0; 200-249 = 3 units; 249-300 = 5 units; 300-349 = 7 units; 350-400 = 10 units >400 = 10 units)." However, April and May 2017 medication record did not indicate the following: <ul style="list-style-type: none"> <li>• Number of Novolog units administered per sliding scale</li> <li>• Administration site</li> </ul>	<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 style="text-align: center;"><i>TO AVOID THIS ISSUE IN THE FUTURE I HAVE REVIEWED THE "INSULIN ADMINISTRATION" WITH THE RN/CCM TO INCLUDE REQUIRED DOCUMENTATION OF # UNITS GIVEN AND ADMINISTRATION SITE.</i></p>	<p style="text-align: right;"><i>8/12/17</i></p>

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☒	<p>§11-100.1-87 <u>Personal care services.</u> (e)            The primary care giver with the assistance of the case manager shall provide training to all substitute care givers and ensure that all services and interventions indicated in the expanded ARCH resident's care plan are provided to expanded ARCH residents by the substitute care giver.</p> <p><b><u>FINDINGS</u></b>            For SCG # 1 &amp; SCG #2: no training provided by case manager to administer the following:</p> <ul style="list-style-type: none"> <li>• Oral medications</li> <li>• Topical medications</li> <li>• Eye medications</li> <li>• Subcutaneous injections</li> <li>• Finger stick glucose checks</li> </ul> <p><b>This is a repeat deficiency from your 2016 annual inspection.</b></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 style="text-align: center;"><i>YES, DELEGATION WAS DONE OF 4/7/2017. DOCUMENTATION NOT IN CHART. PAPER WORK WAS GENERATED AND COMPLETED.</i></p>	<p style="text-align: center;"><i>8/18/17</i></p>



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<input checked="" type="checkbox"/> §11-100.1-87 <u>Personal care services.</u> (e) The primary care giver with the assistance of the case manager shall provide training to all substitute care givers and ensure that all services and interventions indicated in the expanded ARCH resident's care plan are provided to expanded ARCH residents by the substitute care giver.  <u>FINDINGS</u> For SCG # 1 & SCG #2: no training provided by case manager to administer the following: <ul style="list-style-type: none"> <li>• Oral medications</li> <li>• Topical medications</li> <li>• Eye medications</li> <li>• Subcutaneous injections</li> <li>• Finger stick glucose checks</li> </ul> This is a repeat deficiency from your 2016 annual inspection.	<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 style="text-align: center;"><i>I THE RN/CMM WILL FOLLOW MY CHECKLIST FOR ADMISSION REQUIREMENTS AND ALL DOCUMENTATION COMPLETED AS DONE ON-SITE.</i></p>	<p style="text-align: right;"><i>8/18/17</i></p>

Licensee's/Administrator's Signature: Josephine V. Cabal

Print Name: JOSEPHINE V. CABAL

Date: 8/18/2017

Licensee's/Administrator's Signature: Joseph V. Cabal

Print Name: JOSEPHINE V. CABAL

Date: 8/30/17