Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Lydia Quemado (ARCH)	**CHAPTER 100.1**
Address: 94-1292 Huakai Street, Waipahu, Hawaii 96797	**Inspection Date: June 1, 2016 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§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** Resident #1 physician order and medication administration record (MAR) lists Aspirin 325mg. Only Aspirin 81mg made available to resident.	On admission Aspirin WAS ORdered 325 mg so I WAS following it and the DR never change it. When my inspection we notice it so I called the MD and change it To 81 mg. now its okay.	7-26-16
		I Bring the reminder To the MD on my note Pad, To discuss the Med. ORder.	

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		all of those medication was initial then but was near the line and I think it hard to see them. Next time I will make it clearer.	7-26-16
☒	§11-100.1-15 Medications. (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. **FINDINGS** Resident #1 June 1, 2016 no initials on medication administration record (MAR) for administration of the following medications: 1) Coreg 25mg 2) Losartan 100mg 3) Metformin 1000mg 4) Vascepa 1 Gram	When I give the med. I will take the chart and initial it right away.	
☒	§11-100.1-17 Records and reports. (a)(1) 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: Documentation of primary care giver's assessment of resident upon admission; **FINDINGS** Resident #1 no admission assessment for January 8, 2016 admission.	I'm sorry this is my first time to know that every time a Resident goes the Hospital I would write another Admission Assessment	7-26-16
		I put a note in a paper Put it right by the Table so I can remember it	

☒	§11-100.1-17 Records and reports. (b)(7) During residence, records shall include: Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency; **FINDINGS** Resident #1 no monthly weight from February 2016- May 2016.	I put it in the Calendar by the kitchen so every time I can see it and remember it	'17 ... :20

☒	§11-100.1-17 Records and reports. (f)(4) General rules regarding records: All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency. **FINDINGS** Resident #1 emergency sheet medication list not current. Lists discontinued medication Invokana and incorrect dosage of Coreg (12.5mg instead of 25mg).	I change all of it already. When I make the new Emergency sheet. I put the note next to the DR appt in the calendar to double check the emergency sheet.	7-26-16

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