

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name:</b> Villar, Marylin (ARCH)	CHAPTER 100.1
<b>Address:</b> 94-242 Pupukahi Street, Waipahu, Hawaii 96797	<b>Inspection Date:</b> 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.**

	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> Household member - No screening for symptoms consistent with pulmonary tuberculosis (TB). <b>Submit a copy with the plan of correction.</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>Copy of the screening for symptoms consistent with pulmonary tuberculosis (TB) already submitted.</i></p>	<p style="text-align: right;"><i>1/11/17</i></p> <p style="text-align: right;">17 JAN 13 AM 0:54</p> <p style="text-align: right;">RECORDED</p>

	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> Household member - No screening for symptoms consistent with pulmonary tuberculosis (TB). <b>Submit a copy with the plan of correction.</b></p>	<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>I will use the calendar for tracking the annual T.B. screening and I will staple the screening form to the T<sup>BM</sup> PE form to be done in the same time.</i></p>	<p style="text-align: right;"><i>10/2/17</i></p> <p style="text-align: right;">17 JUN -2 10 44</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><b><u>FINDINGS</u></b> Resident #1 - "Docusate sodium 100 mg cap I cap BID prn" ordered 10/3/16; the label reflected "twice daily."</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>I called the doctor to clarify the order the doctor was BID PRN so I will change the label to include PRN.</i></p>	<p style="text-align: right;"><i>6/2/17</i></p> <p style="text-align: right;">17 JUN -2 19:54</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><b><u>FINDINGS</u></b> Resident #1 - "Docusate sodium 100 mg cap I cap BID prn" ordered 10/3/16; the label reflected "twice daily."</p>	<p>Part 2</p> <p><b><u>FUTURE PLAN</u></b></p> <p><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>I will check the label with the doctor's order, if no match call the doctor to clarify the order and have the label changed.</i></p>	<p><i>6/2/17</i></p>
		<p><i>To prevent a similar deficiency from recurring, I will make sure to call the physician and clarify the medication order and tell him doesn't match the physician order to the bottle label.</i></p>	<p><i>1/11/17</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><b><u>FINDINGS</u></b> Resident #1 - "Tamulosin" label noted "Take one-half hour following the same meal each day;" however, the medication record reflected the medication is taken at 6 p.m. Dinner is served 6 p.m. to 7 p.m.</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>I modified the medication order for the medications to be taken at 6:30 PM.</i></p>	<p style="text-align: right;"><i>6/2/17</i></p> <p style="text-align: right;">17 JUN -2 09:54</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><b><u>FINDINGS</u></b> Resident #1 - "Tamulosin" label noted "Take one-half hour following the same meal each day;" however, the medication record reflected the medication is taken at 6 p.m. Dinner is served 6 p.m. to 7 p.m.</p>	<p>Part 2</p> <p><b><u>FUTURE PLAN</u></b></p> <p><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>I will read the special instructions on the label and write on the medication record the time according to the instruction</i></p>	<p>6/2/17</p>
		<p><i>To prevent a similar deficiency from recurring, I will make sure to follow the label note in the bottle with the approval of the doctor before giving the resident's medication and record it to the Resident's medication record.</i></p>	<p>11/11/17</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<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 - The medication record reflected that "Seroquel" and "citalopram" are taken at "HS;" the time of day is not recorded on the medication record.</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>Medication record change to include the time of day.</i></p>	<p style="text-align: right;"><i>6/2/17</i></p> <p style="text-align: right;">17 JUN -2 19:54</p>



	Rules (Criteria)	Plan of Correction	Completion Date
☒	11-100.1-15(m)	<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 style="text-align: center;"><i>To prevent a similar deficiency from recurring, I will make sure to write the date and the exact time when the residents take the perphenazine and citalopram medications and record it to the resident medications record.</i></p>	<p style="text-align: center;"><i>1/11/17</i></p> <p style="text-align: right;"> <small>OFFICE OF THE DIRECTOR OF HEALTH CARE REGULATION</small>  <small>17 JAN 13 AM 5:54</small> </p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(4)  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:</p> <p>A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;</p> <p><b><u>FINDINGS</u></b>  Resident #1 - No two-step TB clearance at the time of admission. There was a single step TB skin test (8/28/15). A two-step TB clearance was placed on 6/13/16 (#1) and 6/28/16 (#2).</p>	<p>Part 1</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>Before admitting a Resident to a care home - Resident must have two-step TB clearance.</i></p>	<p>11/28/14</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(4)  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:</p> <p>A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;</p> <p><b><u>FINDINGS</u></b>  Resident #1 - No two-step TB clearance at the time of admission. There was a single step TB skin test (8/28/15). A two-step TB clearance was placed on 6/13/16 (#1) and 6/28/16 (#2).</p>	<p style="text-align: center;">Part 2</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 will use the admission checklist and I will check the date for the 2 step TB clearance of my step clearance during my admission until complete.</i></p>	<p style="text-align: right;"><i>6/2/17</i></p> <p style="text-align: right;">17 JUN -2 11:54</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (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:</p> <p>Physician or APRN signed orders for diet, medications, and treatments;</p> <p><b><u>FINDINGS</u></b>  Resident #1 - No medication orders at the time of admission.</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 style="text-align: center;"><i>Before admitting a resident to a care home Resident must have a current list of medications or orders sign by the physician.</i></p>	<p style="text-align: center;"><i>11/28/14</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	11-100.1-17(a)(6)	<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 style="text-align: center;"><i>To prevent a similar deficiency from recurring, I will make sure to double check the Resident admission <del>form</del> form, if the physicians written all the Resident's medication signed by the physician before admitting a resident.</i></p>	<p style="text-align: center;"><i>1/11/17</i></p>

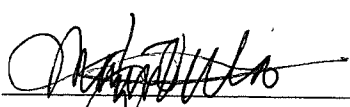
Department of Health  
 17 JAN 13 10:54  
 Pennsylvania

Licensee's/Administrator's Signature: 

Print Name: MARILYN VILLAR

Date: 12/3/14

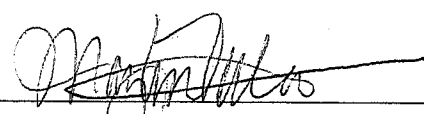
---

Licensee's/Administrator's Signature: 

Print Name: MARILYN T. VILLAR

Date: 1/11/17

---

Licensee's/Administrator's Signature: 

Print Name: MARILYN VILLAR

Date: 6/2/17