Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: A.C.T.G. ARCH #2	**CHAPTER 100.1**
Address: 1447 Uila Street, Honolulu, Hawaii 96818	**Inspection Date: February 14 & 15, 2018 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
☒	§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 weight recorded for the months of November and December 2017. No physician orders not to weight resident on record. No alternative method of assessing nutritional status documented.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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 weight recorded for the months of November and December 2017. No physician orders not to weight resident on record. No alternative method of assessing nutritional status documented.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future I will make sure that All of my residents will be weight at least once a month and more often when requested by a physician, APRN or Responsible Agency Memo was made in such matter to all STAFF. Care Home Operator / Primary Care giver or ACTG RN or Residents Case Manager will obtain a Physicians order. the Care Home Operator for that facility will make sure that such orders are in the Record.	2-15-18 3-11-18 3-11-18 3-11-18

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-88 Case management qualifications and services. (c)(4) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Update the care plan as changes occur in the expanded ARCH resident care needs, services and/or interventions; **FINDINGS** Resident #1 Gastrointestinal and Nutrition Care Plan not updated to reflect change in supplement orders. Care plans calls for "Ensure plus 240ml, 1 can by mouth 2 times a day." No physician orders for ensure plus on record.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Care Manager was informed. Care Plan was corrected/updated. (see attached paper)	2/15/18

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-88 Case management qualifications and services. (c)(4) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Update the care plan as changes occur in the expanded ARCH resident care needs, services and/or interventions; **FINDINGS** Resident #1 Gastrointestinal and Nutrition Care Plan not updated to reflect change in supplement orders. Care plans calls for "Ensure plus 240ml, 1 can by mouth 2 times a day." No physician orders for ensure plus on record.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future I will make sure to have a physician order for Ensure plus. * Ensure plus 240 mL / one can by mouth two times a day was removed from the Care plan. - By Case Manager Care Home Operator / Primary care giver will review Care plan with the Case Manager after each visit to ensure that they are up to date.	2-15-18 2-15-18 3-11-18

Licensee's/Administrator's Signature: Teofista Gallegos

Print Name: TEOFISTA GALLEGOS

Date: 2-22-18

Licensee's/Administrator's Signature: Teofista Gallegos

Print Name: TEOFISTA GALLEGOS

Date: 3-13-18