

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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| Facility's Name: Lita Soria (ARCH/Expanded ARCH) | CHAPTER 100.1 |
| Address: 94-346 Hene Street, Waipahu, Hawaii 96797 | Inspection Date: October 26, 2017 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>§11-100.1-17 <u>Records and reports.</u> (b)(7) During residence, records shall include:</p> <p>Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency;</p> <p>FINDINGS Resident #1, no monthly weights recorded.</p> | <p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p> <p><i>"P/s. see page 3 for future plan"</i></p> | <p style="text-align: right;"><i>1/16/18</i></p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (b)(7) During residence, records shall include:</p> <p>Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency;</p> <p><u>FINDINGS</u> Resident #1, no monthly weights recorded.</p> | <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><i>a.s.</i> In the future plan to get Res. #1 weigh every month on wheelchair scale in between months go for Dr. check ups who has a wheelchair scale. If any future resident need wheelchair scale I will plan to do the same thing as for Res. #1. Go to wheelchair scale in every month and record in resident weight log.</p> | <p>1/16/18</p> |

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|-------------------------------------|--|--|--|
| <input checked="" type="checkbox"/> | <p>§11-100.1-88 <u>Case management qualifications and services.</u> (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:</p> <p>Update the care plan as changes occur in the expanded ARCH resident care needs, services and/or interventions;</p> <p>FINDINGS Resident #1, order dated <u>10/3/17</u> reads, "waive monthly weights and weigh quarterly during office visits." Case management (CM) care plan reads "will not have excessive weight loss/gain over ten pounds in 6 months." RN CM visit dated <u>10/9/17</u>; however, no plan update to identify alternate means to monitor resident's nutritional status.</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>In the nurse consultant findings, a) A Dr note had been written waiving monthly weights and do it quarterly. A decision was made to take resident #1 to various scale monthly despite the inconvenience. that is also the future plan. b) The case management (cm) care plan has a alteration in nutrition/ hydration section is the template. It is not dated and is blank as it is not an identified problem for this client. The quote in client goals re: weight is not part of res. #1's care plan and not referred to is the RN CM notes as they are applicable. Since not applicable, no alternate nutritional assessment would be identified or documented as there is no concern.</p> <p>*The correction of the deficiency is just to weigh monthly on a wheel chair scale and share result with Dr. at quarterly visit/ every 4 visit at MD.</p> | <p style="text-align: right;">11/16/18</p> |

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Licensee's/Administrator's Signature: Angelita A. Sokin

Print Name: ANGELITA A. SOKIN

Date: 1/16/18