

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name: Manayan's ARCH-EC-LLC</b>	<b>CHAPTER 100.1</b>
<b>Address: 1319 Gulick Avenue, Honolulu, Hawaii 96819</b>	<b>Inspection Date: November 15, 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>§11-100.1-15 <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 - The following medications were ordered 10/24/17; however, not provided:</p> <ul style="list-style-type: none"> <li>• Aspirin 81 mg tab take 1 tab po daily for prevention</li> <li>• Doxazosin 2 mg tab take 1 tab po with dinner for HBP</li> <li>• Amlodipine 10 mg tab take 1 tab po daily for HBP</li> <li>• Citalopram 10 mg tab take 1/2 tab (0.5 mg) po daily for dementia</li> <li>• Risperidone 0.35 mg tab take 1 tab po BID for dementia</li> <li>• Allopurinol 100 mg take 1 tab po daily for gout</li> <li>• Indomethacin 25 mg cap take 1 cap po BID prn with food for pain</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><i>The medications has been discontinued on Nov. 15 2017 by TO signed by M.D.</i></p>	

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<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 - Resident #1 - "Ensure 240 cc po TID" ordered 10/24/17; however, not provided.</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>The supplement ENSURE 240 cc PO TID has been discontinued on Nov 15 2017 T.O. signature by MD</p>	

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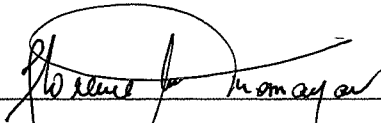
	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(4) During residence, records shall include:</p> <p>Entries describing treatments and services rendered;</p> <p><b><u>FINDINGS</u></b> Resident #1 - "Ensure 240 cc po TID" ordered 10/24/17; however, not provided.</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>The supplement Ensure 240 cc po TID has been discontinued Nov 15 2017 T.O. signed by MD</p>	

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<input checked="" type="checkbox"/> §11-100.1-17 <u>Records and reports.</u> (b)(4) During residence, records shall include:  Entries describing treatments and services rendered;  <u>FINDINGS</u> Resident #1 - "Ensure 240 cc po TID" ordered 10/24/17; however, not provided.	<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>In the future if I have a case manager I will have them both verify and update all medication / supplement of treatment for their care plan and records.</p> <p>1) I will also ensure that all given medication, supplement, treatment to the resident shall be signed by Hospice MD which includes PCP medications, supplement &amp; treatment.</p> <p>2) If the resident still have active MD (PCP) during the time of hospice status I will ensure that his PCP shall also signed all medication / supplement and treatment for verification which include Hospice MD medications so that the Hospice MD and PCP shall agreed with all the medication supplement, treatment given to their resident.</p>	

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (h)(1)(A)  The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p>Housekeeping:</p> <p>A plan including but not limited to sweeping, dusting, mopping, vacuuming, waxing, sanitizing, removal of odors and cleaning of windows and screens shall be made and implemented for routine periodic cleaning of the entire Type I ARCH and premises;</p> <p><u>FINDINGS</u>  One (1) resident bedroom had a strong urine odor.</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>urine spill on the floor, clean it as soon as possible with mop and sanitizing to remove the odor and not hazard to the resident and caregivers.</p> <p>Mattress for resident bed in Bedroom #3 was replaced w/ a new one and also replaced old plastic mattress cover with a new one.</p>	<p style="text-align: right;">11-27-17</p>

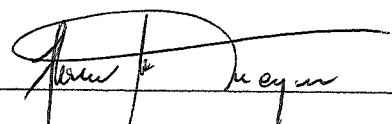


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Licensee's/Administrator's Signature: 

Print Name: FLORENCE MANAYAN

Date: 12-5-17

Licensee's/Administrator's Signature:  CEO

Print Name: Florence Manayan

Date: Feb 28, 2018