

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name: Padre ARCH</b>	<b>CHAPTER 100.1</b>
<b>Address: 94-607 Mahoe Street, Waipahu, Hawaii 96797</b>	<b>Inspection Date: January 11, 2018 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>§11-100.1-9 <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> SCG#1 no evidence of annual tuberculosis clearance.</p> <p><i>SCG #1 - task or done tuberculosis examination.</i></p> <p><i>Amien - 1 - 16 - 2018</i> <i>Date Read - 1 - 18 - 2018</i></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><i>Care giver will schedule substitutes tuberculosis examination, to be done in December annually, and use my calendar as a reminder.</i></p>	<p><i>1-19-2018</i></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> SCG#1 no evidence of annual tuberculosis clearance.</p> <p><i>SCG#1 - took or done tuberculosis examination</i></p> <p><i>Given - 1 - 16 - 2018</i> <i>Date Read - 1 - 18 - 2018</i></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>Care given will schedule substitutes tuberculosis examination to be done in December annually, and use my calendar as a reminder.</i></p>	<p style="text-align: right;"><i>1-19-2018</i></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>FINDINGS</b> Family Member #1 no evidence of annual tuberculosis clearance.</p> <p><i>Family member #1 - Schedule to take P.B Test on January 22, 2018 and readings will be on January 24, 2018</i></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><i>Care giver will schedule all Family members to get a Tuberculosis Examination annually in December, and use my calendar as a reminder to be Done.</i></p>	<p><i>1-19-2018</i></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>FINDINGS</b> Family Member #1 no evidence of annual tuberculosis clearance</p> <p><i>Family member #1 - Schedule to take tuberculosis examination on January 22, 2018 and reading will be on January 24, 2018.</i></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>Care giver will schedule all family members to get a tuberculosis examination annually in December, and I use my calendar as a reminder to be done.</i></p>	<p style="text-align: right;"><i>1-19-2018</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-12 <u>Emergency care of residents and disaster preparedness.</u> (b) The licensee shall maintain a first aid kit for emergency use for each Type I ARCH.</p> <p><b>FINDINGS</b> Thermometer in first aid kit not functioning.</p> <p><i>Care giver purchased a new Thermometer. = 1-17-2018.</i></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><i>Care giver will check first aid kit each month and verify that contents is sufficient, accurate and functioning in working order.</i></p>	<p><i>1-19-2018</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-12 <u>Emergency care of residents and disaster preparedness.</u> (b)  The licensee shall maintain a first aid kit for emergency use for each Type I ARCH.</p> <p><b><u>FINDINGS</u></b>  Thermometer in first aid kit not functioning.</p> <p><i>Care giver purchased a new Thermometer 1-12-2018</i></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>Care giver will check first aid kit each month and verify that contents is sufficient, accurate and functioning in working order.</i></p>	<p><i>1-19-2018</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><b>FINDINGS</b> Resident #1 medication administration record (MAR) missing care giver initials for administration of Potassium CL 20 meq from May 22, 2017 through May 31, 2017.</p> <p><i>I updated and initialed Resd #1 medication Administration Record, of Potassium CL 20 from May 22, 2017 to May 31 2017. 1-11-18</i></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><i>Care giver, make sure after each medication of the Residents, I will Initial their Medication Administration Record everyday after she gave their <sup>daily</sup> medication prescribed by their DR.</i></p>	<p><i>1-19-18</i> <i>B</i></p>



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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><b>FINDINGS</b> Resident #1 medication administration record (MAR) missing care giver initials for administration of Potassium CL 20 meq from May 22, 2017 through May 31, 2017.</p> <p><i>I updated and initialed Resd# 1 medication Administration Record of Potassium CL 20 from May 22-2017 to May 31-2017 1-11-18</i></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>Care giver, make sure after each medication of the Resd, I will initial their medication administration Record every-day after I gave their daily medication prescribed by there DR.</i></p>	<p style="text-align: right;"><i>1-19-18</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><b>FINDINGS</b> Resident #1 medication administration record (MAR) missing care giver initials for administration of Nicotine patch 14mg from November 25, 2017 through November 30, 2017.</p> <p><i>I updated and Initial Resd # 1 Medication Administration Record of Nicotine patch 14mg from November 25, 2017 to November 30, 2017 #11-18-</i></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>Care giver, make sure after each medication of the Resd., I will Initial their Medication Record everyday after I gave their daily medication prescribed by their Doctor.</i></p>	<p><i>1-19-18</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><b>FINDINGS</b> Resident #1 medication administration record (MAR) missing care giver initials for administration of Nicotine patch 14mg from November 25, 2017 through November 30, 2017.</p> <p><i>I updated and Initial Resd #1 Medication administration Record of Nicotine patch 14mg from November 25, 2017 to November 30, 2017 1-11-18</i></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>Care giver: make sure after each medication of the Residents, I will Initial their medication administration Record everyday after I give their daily medication prescribed by their Doctors</i></p>	<p style="text-align: right;"><i>1-19-18</i></p>

Licensee's/Administrator's Signature: Norma Padre

Print Name: NORMA PADRE

Date: 1-19-18