

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Rosana Dumlao (ARCH/Expanded ARCH)	CHAPTER 100.1
Address: 94-871 Awanei Street, Waipahu, Hawaii 96797	Inspection Date: February 3, 3017 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.

Department of Licensing

02:02

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p>FINDINGS Substitute care giver (SCG) #1 - No current physical examination.</p>	<p style="text-align: center;">PART 1 <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>SCG #1 Dr.'s Visit ——— to complete the blank spaces on the ^{P.E} form provided by her Dr.</p>	<p style="text-align: right;">2-11-17</p> <p style="text-align: right;">02:02</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-9 (a)	<p style="text-align: center;"> PART 2 <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>To prevent a similar deficiency I am going to look at the P.E. form they gave me and check if the form is complete before i file it.</i> </p>	<p style="text-align: center;">4-11-17</p>

STATE OF HAWAII
 DEPARTMENT OF LICENSING

17 APR 11 P1:52

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p>FINDINGS SCG #2 - No training to make medications available to residents.</p>	<p style="text-align: center;">PART 1 <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><i>To prevent a similar different I will train the SCG to give medication and document it. Done</i></p> <p><i>I will train the SCG to give medication and document it.</i></p>	<p style="text-align: center;">4-11-17</p> <p style="text-align: right;">17 APR 11 1:52</p> <p style="text-align: right; font-size: small;">STATE OF HAWAII HHS-CHCA-LICENSING</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-9 (e)(4)	<p style="text-align: center;"> PART 2 <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>To prevent a similar deficiency I will train the SCG to give medication and document it and remember to use the checklist provided by OHCA</i> </p>	<p style="text-align: center;">4-11-17</p> <p style="text-align: center;"> 17 APR 11 P1:52 <small>STATE OF HAWAII</small> </p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (a) Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be obtained prior to a resident's admission to a Type I ARCH and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's responsible placement agency, and others authorized by the resident to review it.</p> <p>FINDINGS Resident #1 - No level of care at the time of admission on 4/4/16.</p>	<p style="text-align: center;">PART 1 <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>Resident #1 level of care a Dr's visit was conducted → PCP signed form.</p>	<p style="text-align: center;">2-27-17</p> <p style="text-align: center;">202</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-10 (a)	<p style="text-align: center;"> PART 2 <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>To prevent a similar deficiency I will use the ARCH/EA/EEH admission checklist to make sure the level of course is completed at the time of admission.</i> </p>	<p style="text-align: right;"> <i>4-11-17</i> </p> <p style="text-align: right;"> 17 APR 11 P1:52 </p> <p style="text-align: right;"> <small>STATE OF HAWAII DEPARTMENT OF EDUCATION</small> </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>FINDINGS Resident #1 - "Q-PAP 325 mg 2 tabs every 6 hours pm" ordered 1/31/17; the February 2017 medication record reflected "every 4-6 hours pm."</p>	<p style="text-align: center;">PART 1 <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>Resident #1 Q PAP 325 mg 2 tabs q 6 hours PRN was re-written q 6 hours on my medication record for February 2017</p>	<p style="text-align: right;">2-3-17</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>RULE # §11-100.1-15 (m)</p> <p>In the future I have to make sure that Dr's order and my medication record would be written the same and I have to double check it.</p>	<p>PART 2 <u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p>	<p>2-3-17</p> <p>DATE OF LICENSURE</p> <p>12:02</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(1) 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>Documentation of primary care giver's assessment of resident upon admission;</p> <p>FINDINGS Resident #1 - Emergency Information was not current. Medication list did not include "Fanapt" order.</p>	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Resident #1 Fanapt order was added to Emergency Information.</p>	<p style="text-align: center;">2-3-17</p> <p style="text-align: right;">2:02</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>RULE # §11-100.1-17 (a)(1)</p> <p>In the future I have to review and update Emergency Information everytime theres a changes in medication orders from PCP's.</p>	<p>PART 2 <u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p>	<p>2-3-17</p> <p>2:02</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><u>FINDINGS</u> Resident #1 - No physician order for diet and "Wal-mucil, Senna lax, levothyroxine, multivitamins, tamsulosin, Q-PAP and triamcinolone" at the time of readmission on 4/4/16. Medication taken by the resident.</p>	<p style="text-align: center;">PART 1 <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>Resident #1 Dr. Azyet — meeting + discuss about Resident #1 medications last FR visit + readmission assessment was provided PCP sign + postdate the order of his diet, wal-mucil, Senna lax, levothyroxine, multivitamin tamsulosin, QPAP + Triamcinolone for 4-4-16</p>	<p style="text-align: center;">2-27-17</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-17 (a)(6)	<p style="text-align: center;"> PART 2 <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>To prevent a similar deficiency I will use the HCAH / EAHCA admission checklist to make sure I have a diet order and order for all the medications. if the medication order is incomplete call the Dr. and verify medication orders and document telephone orders.</i> </p>	<p style="text-align: center;">4-11-17</p> <p style="text-align: right;"> <small>STATE OF HAWAII DEPARTMENT OF HEALTH DIVISION OF LICENSING</small> 17 APR 11 P 1:52 </p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p>FINDINGS Resident #1 - No progress notes when resident was sprayed with the fire extinguisher by another resident on 7/26/16.</p>	<p style="text-align: center;">PART 1 <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>Resident #1 progress notes was written ^{re-written} from incident Report form to my monthly progress note.</p>	<p style="text-align: right;">2-4-17</p> <p style="text-align: right;">2:03</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-17 (b)(3)	<p style="text-align: center;"> PART 2 <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>To prevent a similar deficiency I will document in my progress notes right away when incident occurs so I don't forget.</i> </p>	<p style="text-align: center;">4-4-17</p> <p style="text-align: right;"> <small>STATE OF NEW YORK</small> <small>APR 11 4:17 PM '17</small> </p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p>FINDINGS Resident #1 - Progress notes did not reflect resident behavior upon return 4/4/16 following hospitalization for aggressive behavior.</p>	<p style="text-align: center;">PART 1 <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>Resident #1 progress notes SCG had written post dated observation about resident #1 after his hospitalization due to aggressive behavior.</p>	<p style="text-align: center; font-size: 2em;">2-16-17</p> <p style="text-align: right; font-size: 0.8em;">DATE: 2/16/17 TIME: 2:03</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>RULE # §11-100.1-17 (b)(3)</p> <p>In the future I have to make sure SCG must write their assessments & observations of the residents in the progress notes and I have to double check it.</p>	<p>PART 2 <u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p>	<p>2-16-17</p> <p>12:03</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p><u>FINDINGS</u> Resident #1 - Progress notes did not reflect resident's need for and response to PRN Wal-mucil and PRN triamcinolone taken twice daily.</p>	<p style="text-align: center;">PART 1 <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>Resident #1 Wal-mucil PRN & Triamcinolone PRN — observation and responses of this two medication were written in my monthly progress notes.</p>	<p style="text-align: center;">2-4-17</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-17 (b)(3)	<p style="text-align: center;"> PART 2 <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>To prevent a similar deficiency I will document in my progress notes when the resident asked for PRN medication everyday and document the effects.</i> </p>	<p style="text-align: center;">4-11-17</p> <p style="text-align: right;"> <small>STATE OF HAWAII</small> <small>APR 11 2017 11:52</small> </p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(I) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either:</p> <p>FINDINGS Resident #1 - No self-preservation certification at the time of admission on 4/4/16.</p>	<p style="text-align: center;">PART 1 <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><i>Resident # 1</i></p> <p><i>PCP meeting was conducted PCP signed a postdated self preservation form</i></p>	<p style="text-align: right;"><i>2-27-17</i></p> <p style="text-align: right;"><i>2:07</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>RULE # §11-100.1-23 (g)(3)(I)</p> <p>In the future PCG and SCG will review the readmission checklist from DHCA</p>	<p>PART 2 <u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p>	<p>2-27-17</p> <p>12:07</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (p)(5) Miscellaneous:</p> <p>Signaling devices approved by the department shall be provided for resident's use at the bedside, in bathrooms, toilet rooms, and other areas where residents may be left alone. In Type I ARCHs where the primary care giver and residents do not reside on the same level or when other signaling mechanisms are deemed inadequate, there shall be an electronic signaling system.</p> <p><u>FINDINGS</u> Resident #1 - There was a dresser drawer blocking the wall mounted signaling device.</p>	<p style="text-align: center;">PART 1 <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>Resident #1 bed was repositioned and the drawer was moved to a space so as not to block the calling device.</p>	<p style="text-align: center;">2-3-17</p> <p style="text-align: right;">2:07</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>RULE # §11-100.1-23 (p)(5)</p> <p>In the future I have to make sure the drawers or any furniture won't block the calling device on the wall and resident and SCG were notified not to move the furniture so as not to block the calling device</p>	<p>PART 2 <u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p>	<p>2-3-17</p>
		<p>To prevent similar deficiency I will check the room everyday to make sure the call light is not blocked.</p>	<p>4-11-17</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (1) In addition to the requirements in subchapter 2 and 3:</p> <p>A registered nurse other than the licensee or primary care giver shall train and monitor primary care givers and substitutes in providing daily personal and specialized care to residents as needed to implement their care plan;</p> <p><u>FINDINGS</u> SCG #2 - No training by the RN case manager.</p>	<p style="text-align: center;">PART 1 <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>SCG #2 RN CM came to do training. and PCG + SCG checklist forms were signed.</p>	<p style="text-align: center;">2-16-17</p> <p style="text-align: right; font-size: small;">12:07</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	RULE # §11-100.1-83 (1)	<p style="text-align: center;"> PART 2 <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>To prevent similar deficiency I will use the new EATCA resident checklist to make sure that the training is provided by the RN CH.</i> </p>	<p style="text-align: center;">4-11-17</p> <p style="text-align: right;"> <small>STATE OF HAWAII DEPARTMENT OF HEALTH DIVISION OF LICENSING</small> '17 APR 11 P1:53 </p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (5) In addition to the requirements in subchapter 2 and 3:</p> <p>Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents.</p> <p>FINDINGS SCG #1, SCG #2, & SCG #3 - Eleven (11) hours of continuing education courses.</p>	<p style="text-align: center;">PART 1 <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 style="text-align: center;">Interview coordinator was contacted and do interview training for SCG #1, SCG #2, SCG #3</p>	<p style="text-align: center;">2-20-17</p> <p style="text-align: center;">2:07</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>RULE # §11-100.1-83 (5)</p> <p>In the future I have to review the topics that was written in their certificates to prevent double topics.</p>	<p>PART 2 <u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p>	<p>2-20-17</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)(2) 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>Develop an interim care plan for the expanded ARCH resident within forty-eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident;</p> <p><u>FINDINGS</u> Resident #1 - The "Alteration in normal behavior" care plan did not identify goals and interventions.</p>	<p style="text-align: center;">PART 1 <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 style="font-size: 1.2em;">During a home visit by RN CM resident #1 care plan was reviewed and discuss, mark the appropriate box for the goals & intervention of the Alteration in Normal Behavior Care Plan.</p>	2-16-17

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>RULE # §11-100.1-88 (c)(2)</p> <p>FINDINGS Resident #1 - The "Alteration in normal behavior" care plan did not identify goals and interventions.</p>	<p>PART 2 <u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent similar deficiency I will read the care plan and work with the CM to make sure the care plan is complete with goals and intervention.</p>	<p>4-11-17</p> <p>STATE OF HAWAII DEPARTMENT OF HEALTH 17 APR 11 P1:53</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)(2) 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>Develop an interim care plan for the expanded ARCH resident within forty-eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident;</p> <p><u>FINDINGS</u> Resident #1 - The "Alteration in Mobility" care plan did not identify goals and interventions.</p>	<p style="text-align: center;">PART 1 <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 style="text-align: center;">During a home visit by RN CM resident #1 Care Plan was reviewed, discuss, mark the appropriate box for the goals & intervention of The Alteration in Mobility.</p>	<p style="text-align: center;">2-16-17</p>

2-16-17
 80-01

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>RULE # §11-100.1-88 (c)(2)</p> <p><u>FINDINGS</u> Resident #1 - The "Alteration in Mobility" care plan did not identify goals and interventions.</p>	<p style="text-align: center;">PART 2 <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 similar deficiency I will read the care plan and work with the CM to make sure the care plan is complete with goals and intervention.</i></p>	<p style="text-align: center; font-size: 1.5em;">4-11-17</p> <p style="text-align: center; font-size: 0.8em;">STATE OF HAWAII DHHS - HCDA LICENSING</p> <p style="text-align: center; font-size: 0.8em;">17 APR 11 P1:53</p>

Licensee's/Administrator's Signature: Rosana Dumad

Print Name: ROSANA DUMAD

Date: 3-3-17

Licensee's/Administrator's Signature: Rosana Dumad

Print Name: ROSANA DUMAD

Date: 4-11-17