

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Moonlight Vista ARCH	CHAPTER 100.1
Address: 98-1282 Hoohuali Place, Pearl City, Hawaii 96782	Inspection Date: February 14, 2018

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

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STATE OF HAWAII
OFFICE OF HEALTH CARE ASSURANCE

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (g)</p> <p>All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year.</p> <p><u>FINDINGS</u> Resident #1 – Medication orders not reevaluated and signed by the physician every four (4) months. Medication orders reevaluated and signed on:</p> <ul style="list-style-type: none"> • 6/23/2017 • 11/15/2017 • 12/18/2017 • 1/23/2018 	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p>RECEIVED</p> <p>18 FEB 26 PM 2:59</p> <p>STATE OF HAWAII N. HONOLULU</p>

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☒	<p>§11-100.1-15 <u>Medications.</u> (g)</p> <p>All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year.</p> <p><u>FINDINGS</u> Resident #1 – Medication orders not reevaluated and signed by the physician every four (4) months. Medication orders reevaluated and signed on:</p> <ul style="list-style-type: none"> • 6/23/2017 • 11/15/2017 • 12/18/2017 • 1/23/2018 	<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>IN THE FUTURE TO PREVENT THIS FROM HAPPENING AGAIN, I WILL ADD, "MEDICATION ORDERS TO BE REEVALUATED AND SIGNED EVERY 4 MONTHS OR AS ORDERED BY THE PHYSICIAN OR APRN, NOT TO EXCEED 1 YEAR "ON MY REMINDER CHECKLIST IN THE RESIDENTS CHART. I WILL ADD A NOTE ON THE MEDICATION ORDERS IN OUR PO FORM TO STATE, "ALL MEDICATION ORDERS SHALL BE REEVALUATED AND SIGNED BY THE PHYSICIAN OR APRN EVERY 4 MONTHS OR AS ORDERED BY THE PHYSICIAN OR APRN, NOT TO EXCEED 1 YEAR." DURING EACH PHYSICIAN OR APRN MEDICATION REVIEW VISIT/ APPOINTMENT, I WILL CHECK THAT THE FUTURE APPOINTMENT IS SCHEDULED AND NOTATED FOR EVERY 4 MONTHS OR AS ORDERED BY THE PHYSICIAN OR APRN, NOT TO EXCEED 1 YEAR AND ADD THE FUTURE APPT EVENT IN OUR REMINDER CHECKLIST IN THE RESIDENTS CHART AND ON OUR DESK AND COMPUTER CALENDAR.</i></p>	<p>02/14/18</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (5)</p> <p>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 and SCG #2 – No documented evidence of twelve (12) hours of continuing education courses in the past year.</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><i>CORRECTED THE DEFICIENCY BY CONTACTING SCG #1 AND SCG #2 ON 2/14/18, THE SAME DAY AS OUR DOH ON-SITE VISIT AND REQUESTED A COPY OF THEIR 12 HOURS OF CONTINUING EDUCATION COURSES AS PART OF OUR PERSONNEL AND STAFFING REQUIREMENTS WHEN HIRED AS OUR SCG'S FROM 07/01/17 TO 07/14/17. ON 2/20/18, OBTAINED DOCUMENTED EVIDENCE (CERTIFICATES) FROM BOTH SCG #1 AND SCG #2 AND MADE COPIES OF THEIR 12 HOURS OF CONTINUING EDUCATION COURSES FOR OUR RECORDS AND FOR DOH'S STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (SEE ATTACHED).</i></p>	<p>02/20/18</p>

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Licensee's/Administrator's Signature: 

Print Name: MARIBETH RODRIGUEZ

Date: 02/20/18

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