Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Ed & Rose	**CHAPTER 100.1**
Address: **94-1112 Kahuailani Street, Waipahu, Hawaii 96797**	**Inspection Date: July 5, 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
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** SCG #1 – No documented evidence of an initial tuberculosis clearance.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** SCG #1 evidence of an initial and annual tuberculosis clearance form found it & put it in the binder right away	11/5/17

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** SCG #1 – No documented evidence of an initial tuberculosis clearance.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will check it 6 months prior to expiration from the last TB clearance for my substitute caregivers I will give them 3 months before the expiration for them to have enough time to make appointments with their primary doctors. I will put a mark or a sticker reminder for family member, caregivers and residents alike and I will mark A calender on the tab for TB clearance. Staff who will not comply will not be given any schedule.	3/12/18

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-15 Medications. (g) 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. **FINDINGS** Resident #1 – Medication orders not reevaluated and signed by the physician or APRN every four months.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Asked - Request Resident's #1's physician to sign the medication order.	11/10/17

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☒	§11-100.1-15 Medications. (g) 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. FINDINGS Resident #1 – Medication orders not reevaluated and signed by the physician or APRN every four months.	PART 2 FUTURE PLAN USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? I'll be more aware that medication orders should be reevaluated & signed by the physician or APRN every four months, so that i can fulfill & do it on time i will mark my calendar and put an additional tab in each MD orders and reminders indicating the due date & choose A "Red tab" with the word "ITS VERY IMPT" "Dont forget" & to be more on time I'll do it before the beginning of the 3rd month.	3/12/13

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-16 Personal care services. (i) The primary care giver shall provide the opportunity for each resident to have pneumococcal and influenza vaccines and all necessary immunizations following the recommendations of the Advisory Committee on Immunization Practices (ACIP) or resident's physician or APRN. **FINDINGS** Resident #1 – No influenza vaccine since 10/14/2015.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Informed the physician that Res. #1 needs an influenza vaccine & scheduled him for the next home visit.	11/7/19

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-16 Personal care services. (i) The primary care giver shall provide the opportunity for each resident to have pneumococcal and influenza vaccines and all necessary immunizations following the recommendations of the Advisory Committee on Immunization Practices (ACIP) or resident's physician or APRN. **FINDINGS** Resident #1 – No influenza vaccine since 10/14/2015.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Pneumococcal vaccine is good for 10 years. & flu vaccine is every year. In my calendar I will be marking prior to the month the flu vaccine is about to expire. I will put a tab in my calendar the date of the residence flu vaccine is due and need to be Administered & also check my residence binder & put a Red mark on it to make sure that it will not exceed the expiration date like putting a tab with previous year & recent year	3/12/18

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: 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; FINDINGS Monthly progress note for June 2017 is incomplete.	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY Completed The June 2017 progress note & put it to the residence folder	7/6/17

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: 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; FINDINGS Monthly progress note for June 2017 is incomplete.	PART 2 FUTURE PLAN USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? I will do my progress note in a regular manner. The forms must be in every Residence binders and ready to be filled up on the 4th week of each month religiously, like "its a must" thing to do because everything says everything about the residence situation., and for me as a carehome Operator of, not to forget it I'll put a Red tab that it says " IMPT Don't Forget when incident occurs i will document it immediately so all information will be accurate."	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-23 Physical environment. (g)(3)(I) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: 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: **FINDINGS** Four (4) residents are non-self-preserving.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** On July 5, 2017 i made a verbal notice to the 2 families that i chose to be transferred to another facility., & for the next days i also gave them a written notice On July 13, 2017 one Resident unfortunately passed away [redacted] & another Resident were moved to [redacted] Care Home on August 1, 2017.	11/5/17 11/10/17

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☒	§11-100.1-23 Physical environment. (g)(3)(I) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: 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: **FINDINGS** Four (4) residents are non-self-preserving.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will check the form sign by the physicians if a Resident is Self or Non-Self Preserving. I bear in mind that I'm only allowed to maximum of 2 Residents of non-Self Preserving	11/10/17

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-23 Physical environment. (h)(3) 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. All Type I ARCHs shall comply with applicable state laws and rules relating to sanitation, health, infection control and environmental safety; **FINDINGS** PCG is not sanitizing dishes after each use. PCG stated she sanitizes dishes once a day.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Inform all STAFF & family members that we need to sanitize dishes after each use. & give my family members & STAFF the proper procedure on dishwashing or form OHCA SAN 2.	11/5/17

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☒	§11-100.1-23 Physical environment. (h)(3) 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. All Type I ARCHs shall comply with applicable state laws and rules relating to sanitation, health, infection control and environmental safety; **FINDINGS** PCG is not sanitizing dishes after each use. PCG stated she sanitizes dishes once a day.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Always remind myself, family members and staff that we need to sanitize dishes after each use & also hang the form OHCA SAN 2 form in front of the sink & give my caregivers a copy of it also.	11/5/17

Licensee's/Administrator's Signature: _____

Print Name: Rosalinda Ramos

Date: 11/5/17

Licensee's/Administrator's Signature: _____

Print Name: Rosalinda A. Ramos

Date: March 15, 2018