

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Fiesta, Floreliza (ARCH/Expanded ARCH)	CHAPTER 100.1
Address: 94-232 Lehoula Place, Waipahu, Hawaii 96797	Inspection Date: April 17, 2018 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.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	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><u>FINDINGS</u> SCG#1 - No current physical exam.</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 style="text-align: center;"><i>SCG#1 Physical Exam. done on 2/16/18</i></p>	<p style="text-align: center;"><i>2/18/18</i></p>

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<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><u>FINDINGS</u> SCG#1 - No current physical exam.</p>	<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>my future plan is to make sure all the requirements is completed before she/he can start to be my substitute. Include PE, PPD, First Aid CPR, check list training</i></p>	<p><i>4/18/18</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>FINDINGS SCG#12 No documentation of initial 2 step TB clearance. SCG#2 No documentation of annual TB clearance. <i>AF 1</i></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>SCG # 2 scheduled on 4/21/18 for 2 step TB clearance</i> <i>SCG # 1 TB clearance done on 2/16/18</i></p>	<p style="text-align: right;"><i>4/18/18</i></p>

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<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>FINDINGS SCG#12 No documentation of initial 2 step TB clearance. SCG#21 No documentation of annual TB clearance. AF</p>	<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>my future plan is to check^{the} have a check list so I can know the expiration date and it will be updated before the annual inspection.</i></p>	<p><i>4/18/18</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> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p><u>FINDINGS</u> SCG#1 – No current first aid certification.</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 style="text-align: center;"><i>SCG #1 - First Aid done on 2/28/18 - 2/28/20</i></p>	<p style="text-align: center;"><i>4/18/18</i></p>

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	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><u>FINDINGS</u> No documentation that PCG trained SCG #1 to make prescribed medications available to residents.</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>SCG #1 - was trained by me on 4/18/18</i></p>	<p><i>4/18/18</i></p>

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<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><u>FINDINGS</u> No documentation that PCG trained SCG #1 to make prescribed medications available to residents.</p>	<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 style="text-align: center;"><i>my future plan is to train my substitute right away. signed and dated the care giver training. And to make sure checked the check list and double checked with the substitute care giver.</i></p>	<p style="text-align: right;"><i>6/28/18</i></p> <p style="text-align: center;">'18 JUL -2 AM 1:35</p> <p style="text-align: center;">STATE OF HAWAII DOH-CHCA STATE LICENSING</p> <p style="text-align: right; border: 1px solid black; padding: 2px;">RECEIVED</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><u>FINDINGS</u> SCG#1 – No documentation of completion of twelve hours of continuing education courses per 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 style="text-align: center;"><i>SCG#1 - NA 100-hour Preparatory program for State Certification for the Nursing assistant. Completion date 3/7/18</i></p>	<p style="text-align: center;"><i>4/18/18</i></p>

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Licensee's/Administrator's Signature: Paulina C. Fiesta
Print Name: FLORELIJA C. FIESTA
Date: 4/18/18

Licensee's/Administrator's Signature: Paulina C. Fiesta
Print Name: FLORELIJA C. FIESTA
Date: 6/28/18