Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Baptista, Myrna (ARCH)	**CHAPTER 100.1**
Address: **28-2845 Makahana Street, Pepeekeo, Hawaii 96783**	**Inspection Date: January 23, 2015 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-3 Licensing. (a)(4) No person, group of persons, or entity shall operate an ARCH or expanded ARCH without a license previously obtained under and in compliance with this chapter and chapter 321, HRS. The license issued by the department shall be posted in a conspicuous place visible to the public, on the premises of the ARCH or expanded ARCH; **FINDINGS** ARCH license not posted.	At the time of inspection I posted my current license. In the future as soon as I receive the my new license I post it right away	8-9-2018
☒	§11-100.1-9 Personnel, staffing and family requirements. (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.	substitute #1 obtained physical exam. In the future ~~[illegible]~~ I schedule 3 mos in advance to make an appt. I remind substitute #1 to have his physical & will frequently remind him of his appt.	8-9-2018

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	FINDINGS Substitute care giver (SCG) #1 does not have current P.E.	Also I will accompany him to his appt.	8-9-2018
☒	§11-100.1-10 Admission policies. (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. **FINDINGS** Resident #1 No level of care assessment at readmission.	Level of care was done from his physician In the future I want to use my admission check lists when readmitting a resident	8-9-2018
☒	§11-100.1-13 Nutrition. (d) Current menus shall be posted in the kitchen and in a conspicuous place in the dining area for the residents and department to review. **FINDINGS** Menus were not posted in the kitchen and dining areas.	I made a four week menu and posted on the residents dining table and kitchen In the future every Sunday I rotate each menu	8-9-2018
☒	§11-100.1-13 Nutrition. (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit.	I obtained diet order from his physician In the future I want to use my admission checklists when readmitting a resident.	8-9-2018

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	FINDINGS Resident #1 No admission diet order.		
☒	§11-100.1-13 Nutrition. (l) Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets. **FINDINGS** Resident #1 "Low salt" diet ordered; however no special diet menu.	after inspection I discussed with the physician then he changed diet order to regular diet. In the future I want to discuss menus with his physician and clinic nutritionist and would take 4 cycle menu for her review's recommendations	8-9-2018
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 Physician order for "Hydralazine" reflected to "hold" if SBP <100; however, the BP has not been taken. Resident #1 Physician order "Amlodipine" reflected to "hold" if SBP <100; however, the BP has not been taken. Resident #1 Physician order "Losartan" reflected to "hold" if SBP <100; however, the BP has not been taken. Resident #1 Physician order "Carvedilol" reflected to "hold" if SBP <100; however, the BP has not been taken. Physician order "Carvedilol" reflected "hold if HR" < 55; HR not taken. Resident #1 No Physician order "Clonidine" 0.2 mg p.o BID (Tablet) on/around 12/23/2014.	I informed his doctor that I was taking blood pressure before giving the medications and doctor said administer medication without checking blood pressure. In the future I want to make sure that if the doctors orders blood pressure checks before giving meds - I will document blood pressure on the medication records before giving the meds.	8-9-2018

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☒	§11-100.1-15 <u>Medications.</u> (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications. **<u>FINDINGS</u>** Primary care giver (PCG) disposed "Tylenol Codeine 300 mg/30mg" by flushing it down the toilet.	in the future I will dispose all discontinued medications in the garbage ~~with~~ mix with coffee grounds and add little water until dissolves.	8-9-2018
☒	§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. **<u>FINDINGS</u>** Resident #1 Medication flow sheet indicated Digoxin 125 mg instead of 125 mcg.	At the time of my inspection I corrected my medications record. In the future - I double check my medication record w/ the physician order and also check the medications label	8-9-2018
☒	§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: Documentation of primary care giver's assessment of resident upon admission; **<u>FINDINGS</u>** Resident #1 No PCG assessment upon readmission on 10/22/14.	At time of inspection I completed the admission assessment. In the future I will use my checklists when readmitting new residents	8-9-2018
☒	§11-100.1-17 <u>Records and reports.</u> (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or		

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	transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident #1 No 2nd step tuberculin (TB) skin test required for admission.	After inspection I took resident to Dept. of health for his TB test. In the future I will use my checklist of readmitting new residents	8-9-2018
☒	§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** Resident #1 Progress notes 10/30/14, 11/30/14, 1/16/15 do not reflect changes in condition, response to medication/treatments. For example, complaints of bilateral knee pain & response to pain medication.	In the future I will document response to PRN medications on the medication record and check with resident 30 mins after giving meds.	8-9-2018
☒	§11-100.1-17 Records and reports. (b)(6) During residence, records shall include: All recordings of temperature, pulse, respiration as ordered by a physician, APRN or as may appear to be needed. Physician		

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	or APRN shall be advised of any changes in physical or mental status promptly; **FINDINGS** Resident #1 Parameters to hold Carvedilol not reflected on the medication flow sheet.	I contacted with the physician I clarified order and he said his blood pressure is ok and discontinued parameters. If parameters ordered I will write it on the medication record & double check of doctor order.	8-9-2018
☒	§11-100.1-17 Records and reports. (b)(8) During residence, records shall include: Notation of visits and consultations made to resident by other professional personnel as requested by the resident or the resident's physician or APRN; **FINDINGS** Resident #1 Progress notes did not reflect visits/consultations by Physical Therapist.	In the future I will document all visits consultations in progress notes AS soon I get home from doctors visits	8-9-2018
☒	§11-100.1-17 Records and reports. (f)(1) General rules regarding records: All entries in the resident's record shall be written in black ink, or typewritten, shall be legible, dated, and signed by the individual making the entry; **FINDINGS** Resident #1 Medication list initiated by primary care giver was written in blue ink.	I read the rules and only used black ink in my residents records and told all my substitute to use only black ink	8-9-2018
☒	§11-100.1-17 Records and reports. (f)(3) General rules regarding records: An area shall be provided for safe and secure storage of resident's records which must be retained in the ARCH for periods prescribed by state law;	In	

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	FINDINGS PCG stated she disposed of Resident #1 records upon discharge 9/16/14. The resident was readmitted on 10/22/14.	In the future I will keep records for seven years.	8-9-2018
☒	§11-100.1-19 Resident accounts. (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative. **FINDINGS** Resident #1 No signed financial statement.	A assigned financial statement in the resident record. In the future I will use my checklists to readmitting and new residents	8-9-2018

Licensee/Administrator's Signature: Myrna Baptista

Print Name: Myrna Baptista

Date: 8-9-2018