Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Fabia ARCH-EC, L.L.C.	**CHAPTER 100.1**
Address: 94-301 Hilihua Way, Waipahu, Hawaii 96797	**Inspection Date: April 15, 2015 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-17 Records and reports. (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary. **FINDINGS** No incident report for the following: • Discharged Resident #1 – register reads, discharge on 05/24/14 to crisis team for behavior - suicidal. • Discharged Resident #2 – register reads, discharge on 05/18/14 to Kaiser Emergency for shortness of breath.	primary caregiver will inform all substitute caregivers to chart incident reports on the day it occurs. primary caregiver will instruct subcare givers to put completed reports away in executive file of the carehome in separate area. primary caregiver will notify the correct parties such as a resident's physician or APRN if medical care is needed for incident. primary caregiver will check	05/11/18

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-17 Records and reports. (g) All information contained in the resident's record shall be confidential. Written consent of the resident, or resident's guardian or surrogate, shall be required for the release of information to persons not otherwise authorized to receive it. Records shall be secured against loss, destruction, defacement, tampering, or use by unauthorized persons. There shall be written policies governing access to, duplication of, and release of any information from the resident's record. Records shall be readily accessible and available to authorized department personnel for the purpose of determining compliance with the provisions of this chapter. **FINDINGS** Resident register, "white-out" use on resident number, sex, age, religion, marital status, name, diagnosis, referral source and for the date (06/17/14) of admission.	primary caregiver will remind all substitute caregivers of the designated times to do their charting. primary caregiver will check their charting and remind staff not to use white out when trying to correct an Error. Primary caregiver will educate staff on proper correction by drawing a line through word and inital with DATE.	5/11/18
☒	§11-100.1-17 Records and reports. (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** Discharged Resident #2 - permanent general register read, resident was discharged on 05/18/14. However, per primary care giver (PCG), resident was taken to emergency room on 05/18/14 and discharged on the following day, 05/19/14.	primary care giver will do the carehome register right after another agency or family has taken full responsibility for a Resident. primary caregiver will document correct dates.	5/11/18

Licensee's/Administrator's Signature: Ninfa Fabia

Print Name: Ninfa Fabia

Date: 6/11/18

Licensee's/Administrator's Signature: Ninfa C. Fabia

Print Name: NINFA C. FABIA

Date: August 11, 2016

- handed in 8/11/16 if mail will be late

Licensee's/Administrator's Signature: Ninfa C. Fabia

Print Name: NINFA C. FABIA

Date: Feb. 5, 2017