

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 12, 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
<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><u>FINDINGS</u> Substitute care giver (SCG) #1, new hire July 2016. No initial two step tuberculosis clearance prior to contact with residents.</p>	<p>See attached PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> <i>Supported document Rules 11-1001-9</i> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Make a list of all required documents for SCG #1 and cross check that all needed documents for new hired employee are in their files; TB clearance - make a note that is done yearly.</i></p>	<p><i>Yes, 05/18/17</i></p> <p>1-29-18</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)(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 first aid certification.</p>	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>See attached document - was missing at the time of inspection but found</i></p> <p><i>To correct - PCC make 2 copies from hard copy 1 for file and 1 for back up in case missing. (FA - First aid certificate)</i></p>	<p><i>yes, expired 01/30/18 inspection 04/12/17 but found</i></p> <p><i>1-29-18</i></p>

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	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1, medication made available does not reflect order. Order dated 04/06/17 reads, "Nicotine <u>21 MG/24 HR Patch</u>". Pharmacy dispensed container label reads, "Nicotine <u>14 MG/24 HR Patch</u>". Medication administration record (MAR) reads, "Nicotine <u>21 MG/24 HR patch</u>" made available daily 04/07/17- 04/11/17.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p style="text-align: center;"><i>Sorry</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>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;</p> <p><u>FINDINGS</u> Resident #1, order dated 04/06/17 reads, "Limit water intake to 1500 ml/day". No documentation describing water intake.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p><i>Sorry</i></p>

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	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(2) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident;</p> <p><u>FINDINGS</u> Resident #1, readmit 04/06/17. No interim care plan.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

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	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(6) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Coordinate care giver training, hospital discharge, respite, home transfers and other services as appropriate. Facilitate, advocate and mediate for expanded ARCH residents, care givers and service providers to ensure linkages and provision of quality care for the optimal function of the expanded ARCH resident;</p> <p><u>FINDINGS</u> Resident #1, no training for care givers provided by case manager to address fluid restriction order.</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>notified my nurse case manager regarding this deficiency and she will develop a delegation and teaching form on fluid restriction.</i></p>	<p style="text-align: right;"><i>1-29-18</i></p>

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Licensee's/Administrator's Signature: Nina C. Fabia
Print Name: NINFA C-FABIA
Date: 01-29-2018

Licensee's/Administrator's Signature: Nina C. Fabia
Print Name: NINFA C. FABIA
Date: May 7, 2018