

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Gloria V. Atmospera, ARCH	CHAPTER 100.1
Address: 3544 Pahoehoe Avenue, Honolulu, Hawaii 96816	Inspection Date: June 15, 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>§11-100.1-15 <u>Medications.</u> (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.</p> <p><u>FINDINGS</u> Resident #1 – Medication orders not reevaluated or signed by the physicians every four months.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</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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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p><u>FINDINGS</u> Resident #1 – Medication orders not reevaluated or signed by the physicians every four months.</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>From now on, I'm going to make a list of all my residents which lists their appointments for medication re-evaluation and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year. This will help me keep in track of when/what month they're due for their next re-evaluation.</i></p> <p><i>I will also make a note on my calendar every three months to ensure doctor's appointments are scheduled accordingly.</i></p>	<p>6-16-18 (See attached)</p>

GLORIA V. ATMOSPORA ARCH AND EARCH
3544 PAHOA AVE.
HONOLULU, HAWAII 96816

CHECKLISTS FOR RESIDENTS:

<u>RESIDENT'S NAME:</u>	<u>MEDICATION RE-EVALUATION DOCTORS APPOINTMENT (4 MONTHS)</u>	<u>PHYSICAL EXAM DUE:</u>	<u>T.B. TEST DUE:</u>
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|----------|-------|-------|-------|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ |
| 5. _____ | _____ | _____ | _____ |

Licensee's/Administrator's Signature: Gloria V. Atmospera

Print Name: GLORIA V. ATMOSPORA

Date: 6-18-18