

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Downey, Norma ARCH	CHAPTER 100.1
Address: 4038 Salt Lake Blvd., Honolulu, Hawaii 96818	Inspection Date: September 14, 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>§11-100.1-8 <u>Primary care giver qualifications.</u> (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall:</p> <p>Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current;</p> <p><u>FINDINGS</u> No evidence of six (6) hours of completed training sessions within past year. PCG completed three (3) hours of training.</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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<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 & SCG #2 – No current First Aid certification. First Aid expired March 2018.</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>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:</p> <p>Be currently certified in cardiopulmonary resuscitation;</p> <p><u>FINDINGS</u> SCG #1 & SCG #2 – No current cardiopulmonary resuscitation (CPR) certification. CPR expired March 2018.</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>	

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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 – Physician order sheets dated 1/26/18 & 4/23/18, incomplete medication orders. Physician stated on both order sheets, “Cont same meds.”</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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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (h) All telephone and verbal orders for medication shall be recorded immediately on the physician's order sheet and written confirmation shall be obtained at the next physicians visit and not later than four months from the date of the verbal order for the medication.</p> <p><u>FINDINGS</u> Resident #1 – No physician order to discontinue “Simvastatin 20mg 1 tab by mouth every evening.” PCG indicated on MAR to stop medication on 9/19/17.</p> <p>Resident #1 – No physician order to discontinue “Fenofibrate 160mg 1 tab by mouth daily.” PCG indicated on MAR to stop medication on 5/12/18.</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>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(C) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Each Type I ARCH shall have a written plan for the safe care and evacuation of residents to areas of refuge in case of emergency. This plan shall be reviewed, and updated as necessary, whenever there is a significant change in the physical or mental condition of a resident or whenever a new resident enters the facility. All personnel shall be instructed in their respective duties in carrying out this plan. The written plan with directional diagrams shall be posted in a conspicuous location within the facility;</p> <p><u>FINDINGS</u> No fire escape plan posted in ARCH.</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>	

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____