Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Abad, Edna (ARCH)	**CHAPTER 100.1**
Address: **98-312 Kaluamoi Drive, Pearl City, Hawaii 96782**	**Inspection Date: April 1, 2016 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** Substitute care giver (SCG) #2, no annual tuberculosis (TB) skin test. **Please submit documentation with the plan of correction (POC).**		
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. **FINDINGS**		

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	SCG #1, #2, and #3, no documentation for training by the primary care giver (PCG) on how to make medications available and how to provide resident care. **Please submit documentation with the POC.**		
☒	§11-100.1-14 Food sanitation. (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies. **FINDINGS** Repeat citation (2015). Toxic household chemical "Clorox Fresh Meadow Scent" unsecured in the family bathroom.		
☒	§11-100.1-15 Medications. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. **FINDINGS** Resident #1, physician orders read, "Depakote ER" and "Invega". Pharmacy labeled bottles read, "Divalproex" and "Paliperidone".The pharmacy labels do not match the physician orders. **Please clarify orders with physician.**		
☒	§11-100.1-15 Medications. (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator		

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	shall be properly labeled and kept in a separate locked container. **FINDINGS** Medications ("Afrezza" and "Tanzeum"), labeled for Household Members, unsecured in kitchen refrigerator.		
☒	§11-100.1-15 Medications. (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. **FINDINGS** Resident #1, physician order dated 01/26/16 reads, "Sudafed 60 mg 1 tab BID x 7 days". PCG states medication made available; however, physician order was not transcribed to medication administration record (MAR). No initials in MAR.		
☒	§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 files monthly; however, notes were incomplete as follows: 1. Resident refusing mental health clinic services		

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	resulting in loss of case manager services. 2. No observations indicating need for short-term medication or the resident response to orders. 3. No observations indicating need for medication "Chobetasol 0.05% Cream BID" to face made available on May 19-25, 2015, November 10-16, 2015 and March 1-7, 2016 at 8 a.m. and 4:00 p.m. 4. No observations indicating weight change, resident gained seven (7) pounds during the previous year.		
☒	§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 reports indicating unusual resident behaviors such as verbal aggression, bedwetting, and urinating on rugs.		
☒	§11-100.1-17 Records and reports. (e) In the event of an emergency, an oral summary of the resident's condition shall be provided to the receiving facility, followed by a written transfer summary. **FINDINGS** Resident #1, "Resident Emergency Information" form dated 3/16, many areas were blank (kin, mobility, TB skin test).		

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☒	§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; **FINDINGS** Resident records, for current residents placed on top of the dining table and one (1) discharged resident record placed on top of a chest, all records unsecured on the second floor.		

Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____