Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: **Jamandre, Evangeline G. (ARCH/ Expanded ARCH)**	**CHAPTER 100.1**
Address: **2030 Uhu Street, Honolulu, Hawaii 96819**	**Inspection Date: January 11, 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
☒	§11-100.1-9 Personnel, staffing and family requirements. (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. **FINDINGS** Household Member #1 No annual physical examination.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	**RULE #** §11-100.1-9 (a)	**PART 2** **<u>FUTURE PLAN</u>** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**	

	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** Household Member #1 No annual TB clearance.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	**RULE #** §11-100.1-9 (b)	**PART 2** **<u>FUTURE PLAN</u>** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§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** Substitute care givers #1, #2 No documentation of training by primary care giver to make medications available and document such action.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	**RULE #** §11-100.1-9 (e)(4)	**PART 2** **<u>FUTURE PLAN</u>** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-15 Medications. (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident. **FINDINGS** Resident #1 Aspirin 81 mg QD ordered and made available to resident and not recorded for 8/16, and 9/16 medication administration record.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	**RULE #** §11-100.1-15 (f)	**PART 2** **<u>FUTURE PLAN</u>** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§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 No progress notes reflecting response to PRN Tylenol 500 mg QID made available 5/14/16, BID on 6/16, 7/16, 8/16, 10/16, 11/16, 12/16 and on 1/1/17 through 1/10/17. No progress notes reflecting response to PRN nebulizer Albuterol 25 mg/3ml Q4 hours 5/15/16, 5/17/16, 5/19/16, 5/21/16, 5/23/16, 5/27/16, 5/29/16, 7/4/16, 7/5/16, 8/9/16, 8/15/16, 9/18/16, 12/23/16, 12/26/16, 12/28/16, 1/2/17, and 1/5/17.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	**RULE #** §11-100.1-17 (b)(3)	**PART 2** **<u>FUTURE PLAN</u>** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-17 Records and reports. (b)(8) During residence, records shall include: Notation of visits and consultations made to resident by other professional personnel as requested by the resident or the resident's physician or APRN; **FINDINGS** Resident #1 No progress note reflecting podiatrist visit 6/6/16.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	**RULE #** §11-100.1-17 (b)(8)	**PART 2** **<u>FUTURE PLAN</u>** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-20 Resident health care standards. (c) The primary and substitute care giver shall be able to recognize, record, and report to the resident's physician or APRN significant changes in the resident's health status including, but not limited to, convulsions, fever, sudden weakness, persistent or recurring headaches, voice changes, coughing, shortness of breath, changes in behavior, swelling limbs, abnormal bleeding, or persistent or recurring pain. **FINDINGS** Resident #1 lost three pounds between 8/16 and 9/16. No documentation that change in physical status reported to physician.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	**RULE #** §11-100.1-20 (c)	**PART 2** **<u>FUTURE PLAN</u>** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**	

Licensee's/Administrator's Signature: _________

Print Name: _____

Date: _____