

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name: Aliga, Nelly (ARCH/Expanded ARCH)</b>	<b>CHAPTER 100.1</b>
<b>Address: 174 Lukia Street, Hilo, Hawaii 96720</b>	<b>Inspection Date: January 15, 2019</b>

**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>§11-100.1-9 <u>Personnel, staffing and family requirements.</u>  (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.</p> <p><b><u>FINDINGS</u></b>  Substitute care giver (SCG) #1 and SCG #2, provided resident care while primary care giver (PCG) was on leave from January 29, 2018 – February 5, 2018 – no evidence of current physical examination.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>Substitute no. 1 + 2 are no longer my substitute</i></p>	<p style="text-align: center;"><i>2-14-18</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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.</p> <p><u>FINDINGS</u> Substitute care giver (SCG) #1 and SCG #2, provided resident care while primary care giver (PCG) was on leave from January 29, 2018 – February 5, 2018 – no evidence of current physical examination.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>I will make a list of all the care giver + household members date of P.E + TB clearance. I kept in front care home folder + check every month. I will remind them a month before expired. so I will update my list as I file documents</i></p>	<p style="text-align: right;"><i>1/15/19</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u>  (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.</p> <p><b>FINDINGS</b>  Household member (HM) #1 – no documented evidence of examination for infectious diseases.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>I took household member to the Doctor and obtain P.E on Feb-1, 2019, and I filed on my Care Home folder</i></p>	<p style="text-align: right;"><i>2-1, 2019</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u>            (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.</p> <p><u>FINDINGS</u>            Household member (HM) #1 – no documented evidence of examination for infectious diseases.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>I will make a list of all the care giver + household members, date of BPE + TB clearance. I kept in front of the care home folder + check q month. I will remind them a month before expired</i></p>	<p style="text-align: right;"><i>1-29-19</i></p>

	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><b><u>FINDINGS</u></b> SCG #1 and SCG #2, provided resident care while primary care giver (PCG) was on leave from January 29, 2018 – February 5, 2018 – no current tuberculosis (TB) attestation.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>substitute no. 1 + 2 are no longer my substitute</i></p>	<p style="text-align: center;"><i>2/14/19</i></p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p><b><u>FINDINGS</u></b> Resident #1, no October 2018 medication record.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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><b><u>FINDINGS</u></b> Resident #1, physician order dated May 18, 2018 read, "Cipro 250 mg 1 BID #6." However, no documentation of reason for administration or response to medication.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (h)(3)  The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p>All Type I ARCHs shall comply with applicable state laws and rules relating to sanitation, health, infection control and environmental safety;</p> <p><u>FINDINGS</u>  Two (2) residents sharing one (1) bar of bath soap.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>so bought a liquid soap for everybody.</i></p>	<p style="text-align: center;"><i>1/29/19</i></p>

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Licensee's/Administrator's Signature: Nelly Aliga

Print Name: NELLY Aliga

Date: 3-8-19



Licensee's/Administrator's Signature: Nelly Aliga

Print Name: NELLY Aliga

Date: 4-8-19

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