

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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| <b>Facility's Name: Dalere, Francisca (ARCH)</b>          | <b>CHAPTER 100.1</b>                   |
| <b>Address:<br/>303-A Kulana Road, Hilo, Hawaii 96720</b> | <b>Inspection Date: March 27, 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.**

|                                     | <b>RULES (CRITERIA)</b>  | <b>PLAN OF CORRECTION</b>  | <b>Completion Date</b> |
|-------------------------------------|--|--|------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u><br/>(b)<br/>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><br/>Substitute care giver (SCG) #1, tuberculosis (TB) skin test administered on February 5, 2019. However, no date or results of reading.</p> | <p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> |                        |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications.</u> (m)<br/>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><br/>Resident #1, March 2019 medication record – all medications not initialed as administered on March 26, 2019 (pm dose) and March 27, 2019 (am dose).</p> | <p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> |                        |

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Licensee's/Administrator's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_