

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Guerrero, Miriam (ARCH)	CHAPTER 100.1
Address: 66 Kaiwiki Road, Hilo, Hawaii 96720	Inspection Date: February 27, 2019

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><u>FINDINGS</u> Substitute care giver (SCG) #2 – no current physical examination.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Substitute caregiver No. 2 is no longer my substitute, he is relocating + got a job out of state</i></p>	<p><i>March 10/19</i></p>

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<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><u>FINDINGS</u> SCG #1, tuberculosis (TB) attestation completed on November 26, 2018. No documented past positive TB skin test.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Substitute caregiver No. 1 is coming back for Phil. on Nov. 21/19 I will let him secure the document on his positive skin test on May 22/19.</i></p>	<p><i>May 22/19</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1, physician order dated January 31, 2019 read: <ul style="list-style-type: none"> • “Metoprolol Tartrate <u>25</u> mg 1 tab BID.” February 2019 medication record and prescription label read: <ul style="list-style-type: none"> • “Metoprolol tartrate <u>50</u> mg BID” </p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>As of 6/5/19 I obtain a current prescription w/ correct dosage & instructions on a label w/c is: metoprolol tartrate 50mg BID</i></p>	<p style="text-align: center;"><i>6/5/19</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(3) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>Documentation of date of referral and admission, referral agency with address and telephone number, place or source from which admitted, physician, APRN, dentist, ophthalmologist, optometrist, psychiatrist, and all other medical or social service professionals who are currently treating the resident, next of kin, legal guardian, surrogate or other legally responsible agency;</p> <p><u>FINDINGS</u> Resident #1, resident emergency information sheet did not list medications.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>Has been corrected, all the medications that the resident is taking has been documented on emergency information form</i></p>	<p style="text-align: right;"><i>3/10/19</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(7) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>Height and weight measurements taken;</p> <p><u>FINDINGS</u> Resident #1, admitted on February 3, 2019, no admission height and weight.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</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> (g)(3)(I) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either:</p> <p>FINDINGS Resident #1, admitted on February 3, 2019, no self-preservation statement.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Self preservation was completed on 6/6/19 & signed by Dr. Paylor</i></p>	<p style="text-align: right;"><i>6/6/19</i></p>

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Licensee's/Administrator's Signature: Miriam S. Guerrero

Print Name: MIRIAM S. GUERRERO

Date: _____

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Print Name: MIRIAM S. GUERRERO

Date: May 14 / 19

Licensee's/Administrator's Signature: Miriam S. Guerrero

Print Name: MIRIAM S. GUERRERO

Date: 6/10/19