STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Ilar, Emelyn (ARCH/Expanded ARCH)	**CHAPTER 100.1**
Address: **1712 Keone Street, Hilo, Hawaii 96720**	**Inspection Date: August 14, 2018**

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.

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	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) #1, hired January 2018, no two (2) step tuberculosis (TB) skin test.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** 2 step TB skin test has been done + completed on Dec 20/18	2/27/19

	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) #1, hired January 2018, no two (2) step tuberculosis (TB) skin test.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Future plan- To avoid that this will not happen again, I go back to my checklist before hiring a substitute - that 2 step is needed & after its done she/he will submit it to me & keep on my folder.	2/21/19

	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** SCG #1, no training provided by the PCG to administer resident medications. **This is a repeat deficiency from your 2017 annual inspection.**	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, it has been corrected. I gave training to my SCG #1 on Aug. 17/18	2/27/19

	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** SCG #1, no training provided by the PCG to administer resident medications. **This is a repeat deficiency from your 2017 annual inspection.**	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will make sure that I trained them before I hired my CNA and to remind me of I will make checklist of what they need such as P.E. T.B test CPR + First Aide Basic Training Skills and keep + log in in my care home folder. Whenever I hire someone I have to check in my care home checklist if everything is there and done what needs to be done in order to ~~hire~~ work ~~someone in~~ in in my care home.	5/28/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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, the following medications removed from the prescription labeled box: • "Novolog Flex Pen" • "Levemir FlexTouch"	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** after the findings of this deficiency during inspection date on Aug. 14, 2018 I corrected it right away by returning the medications Novolog flexpen + Levemir flexpen touch to their labelled box.	7/28/19

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☒	§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, the following medications removed from the prescription labeled box: • "Novolog Flex Pen" • "Levemir FlexTouch"	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Never to remove medications from labeled box w/instructions noted, date when picked up and expiration as well. Remind substitutes not to take out medicines from the prescription labeled box.	2/27/19

	RULES (CRITERIA) .	PLAN OF CORRECTION	Completion Date
☒	§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 shall be properly labeled and kept in a separate locked container. **FINDINGS** Resident #1, date opened was not indicated on the following medications: • "Novolog Flex Pen" (Instructions read – "Discard each pen 28 days after first use") • "Levemir FlexTouch (Instructions read – "Discard each pen 42 days after first use")	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Was corrected & the date was indicated on these medications Novolog Flex Pen & Levimir Flex touch.	3/30/19

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☒	§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 shall be properly labeled and kept in a separate locked container. **FINDINGS** Resident #1, date opened was not indicated on the following medications: • "Novolog Flex Pen" (Instructions read – "Discard each pen 28 days after first use") • "Levemir FlexTouch (Instructions read – "Discard each pen 42 days after first use")	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this issue in the future I will label all multidose medications on the day it is opened. I will also note + highlight the expiration date and the discard instructions. To avoid forgetting I will returned all multidose meds to the appropriate labelled box after administering. In addition I will write in the calendar the date I opened in order to know when to discard after first use.	2/28/19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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 shall be properly labeled and kept in a separate locked container. **FINDINGS** Medication bin unlocked.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Bin was locked on 8/14/18	2/27/19

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☒	§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 shall be properly labeled and kept in a separate locked container. **FINDINGS** Medication bin unlocked.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future to ensure that this deficiency will not happen again I will always store all medications in a locked container or cabinet ~~every~~ after administering my patients medication. Also in order not to forget I will put a reminder outside the cabinet saying "Always keep locked after use. Put the sign infront of the locker to remind them always locked after they given the medication. I'll check them daily if is locked or not.	5/28/19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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 shall be properly labeled and kept in a separate locked container. **FINDINGS** Unsecured "Levothyroxine 100 mcg (Synthroid)" brought out of resident room by SCG.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Deficiency was corrected on 8/14/18 medication Levothyroxine was placed back to secured locked cabinet. Even though it was mail ordered to patient, still have to be placed in a secured cabinet.	2/27/19

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☒	§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 shall be properly labeled and kept in a separate locked container. **FINDINGS** Unsecured "Levothyroxine 100 mcg (Synthroid)" brought out of resident room by SCG.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Any mail ordered Rx addressed to patient will be opened by said patient that is addressed to and tell the resident that it should be kept in a locked cabinet.	2/27/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1, the following medications initialed on the November 2017 – January 2018 medication record as administered November 22, 2017 – January 4, 2018: • "Mag-tab SR 84 mg BID" – D/C 11-22-17 • "Potassium CL 20 mcg packed QD" – D/C 11-22-17	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1, November 2017 medication record read, "Calcitonin – Salmon 200 units QD." However, physician order dated November 22, 2017 read, "Calcitonin-Salmon 200 units one spray into one nostril QD." Route of administration was not documented on the medication record.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

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☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1, physician orders read the following: • November 22, 2017 read, "Calcitonin – Salmon 200 units one spray into one nostril QD." • March 8, 2018 read, "Calcitonin – Salmon 200 units one spray into each nostril." • June 13, 2018 read, "Calcitonin – Salmon 200 units one spray into one nostril QD." However, prescription label read, "Calcitonin – Salmon Nasal spray 200 unit/Act use 1 spray daily in alternating nostrils." All physician orders did not match the prescription label and no clarification with physician.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

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☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1, physician orders read the following: • November 22, 2017 read, "Calcitonin – Salmon 200 units one spray into one nostril QD." • March 8, 2018 read, "Calcitonin – Salmon 200 units one spray into each nostril." • June 13, 2018 read, "Calcitonin – Salmon 200 units one spray into one nostril QD." However, prescription label read, "Calcitonin – Salmon Nasal spray 200 unit/Act use 1 spray daily in alternating nostrils." All physician orders did not match the prescription label and no clarification with physician.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Before leaving doctor's office I check physician's orders, even when I pick up medication I check the instruction on the Rx bottle & match up physician's orders	3/30/19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1, physician orders dated November 22, 2017 and March 8, 2018 and monthly medication record read, "Lactulose 10 mg/15 ml solution." However, no clarification order obtained to include dose, frequency, and reason for administration.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

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☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1, physician order dated November 22, 2017 read, "Aspirin 81 mg PO daily for CVA prevention." However, medication was not listed on the November – December 2017 medication record.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

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☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1, physician order dated January 4, 2018 read: • "Calcitonin-Salmon 200 units one spray into one nostril QD." December 2017 – February 2018 medication record read: • "Calcitonin-Salmon 200 units one spray into each nostril." Prescription label read: • "Calcitonin – Salmon Nasal spray 200 unit/Act use 1 spray daily in alternating nostrils." Instructions for administration differed on the physician order, medication records and prescription label.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I checked w/ the doctor the correct physicians orders & doctor called the pharmacy for the correct label & document the right one on MAR	3/30/19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications. **FINDINGS** Resident #1, medication bin contained "Levothyroxine 75 mcg – expired 03/13/18."	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Levothyroxine 75mcg that is expired was disposed using undesirable coffee grounds.	2/27/19

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☒	§11-100.1-15 Medications. (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications. **FINDINGS** Resident #1, medication bin contained "Levothyroxine 75 mcg – expired 03/13/18."	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this issue in the future I will always double check the expiration date of the bottle every time I give the medication.	5/28/19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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 January 4, 2018 read, "Nystatin 100,000 u/gram topical powder apply to groin by topical route 2 times per day x 14 days." However, medication was not listed on the January 2018 medication record.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

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☒	§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 January 4, 2018 read: • "Novolog Flex Pen 100u/ml sliding scale -Blood Sugar 50 – 100 = 3 units 101 – 150 = 5 units 151 – 200 = 6 units 201 – 250 = 7 units 251 – 300 = 8 units 301 -> 9 units • "Levemir Flex Touch 100u/ml inject 5 units HS." However, both medications were not listed on the January 2018 – March 2018 medication records.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

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☒	§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 orders dated March 8, 2018 and June 13, 2018 read: • "Novolog Flex Pen 100u/ml with q meal 3 times a day 4 – 9 units dx DM2." • "Increase Levemir 5 – 10 units at night." However, both medications were not listed on the March – August 2018 medication records.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** It has been corrected medications administered were documented on MAR on 8/15/18	2/27/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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 orders dated March 8, 2018 and June 13, 2018 read: • "Novolog Flex Pen 100u/ml with q meal 3 times a day 4 – 9 units dx DM2." • "Increase Levemir 5 – 10 units at night." However, both medications were not listed on the March – August 2018 medication records.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To ensure that this deficiency will not happen again I will always review all new order of medications by the physician and I will document immediately to the MAR after I got the order + after administering residents medication. – I'll double check again on the physician order the MAR if I documented correctly before starting a new month.	4/24/19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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 November 22, 2017 read, "Tylenol 500 mg PO every 6 hr. PRN pain." However, medication was not listed on the November 2017 – March 2018 medication record.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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 November 22, 2017 read, "Tylenol 500 mg PO every 6 hr. PRN pain." However, medication was not listed on the November 2017 – March 2018 medication record.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future I will ask then the list of medication before I admit the resident then I will review the physician order before documented it in the MAR. I'll double check the physician order to match it to the MAR. In order to documented on the MAR I will make sure that before beginning of the month I double check again the ~~physic~~ physician order and the MAR if it matches then I documented in the MAR.	5/29/19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(1) 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: Documentation of primary care giver's assessment of resident upon admission; **FINDINGS** Resident #1, admitted on November 21, 2017, no admission assessment completed by the PCG.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(1) 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: Documentation of primary care giver's assessment of resident upon admission; **FINDINGS** Resident #1, admitted on November 21, 2017, no admission assessment completed by the PCG.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will always refer to admission check list on every admission of a resident & nothing will be missed & be done immediately.	3/30/19

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APR 08 2019

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(4) 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: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident #1, admitted on November 21, 2017, TB skin test immunization record indicated: • 1st step administered August 26, 2017 – "negative" • 2nd step administered September 19, 2017 – "negative" However, the date of reading was not documented. TB skin test did not follow Department of Health tuberculosis examination procedures. **This is a repeat deficiency from your 2017 annual inspection.**	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** After my inspection 8/15/18 I went to legacy facility to verify when was the skin test read unfortunately, they say they dont have any record anymore of the said Resident instead saying that it was record after 3 days the skin test was given that means first step skin test given on Aug. 26 2017 + was read Ag. 29, 2017 then 2nd step given on Sept. 19. 2017 means it was read on Sept. 22, 2017.	8/29/19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(4) 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: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident #1, admitted on November 21, 2017, TB skin test immunization record indicated: • 1st step administered August 26, 2017 – "negative" • 2nd step administered September 19, 2017 – "negative" However, the date of reading was not documented. TB skin test did not follow Department of Health tuberculosis examination procedures. **This is a repeat deficiency from your 2017 annual inspection.**	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future upon admission I will make sure that all required documents has been completed like this two step skin test when was given read + the results of both skin test in order not to have this difficeing again Also I will check all the documents as required before leaving the facility so I can verify or correct it right away.	5/29/19

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MAY 29 2019

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(6) 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: Physician or APRN signed orders for diet, medications, and treatments; **FINDINGS** Resident #1, admitted on November 21, 2017, annual physical examination form signed on October 26, 2017 read, "regular." However, physicians orders dated October 26, 2017 read, "Mechanical soft diet heart healthy 1800 calorie Diabetic diet." No clarification order obtained.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** On Resident #1 office visit, I did clarify with the physician the correct order and follow.	2/27/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(6) 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: Physician or APRN signed orders for diet, medications, and treatments; **FINDINGS** Resident #1, admitted on November 21, 2017, annual physical examination form signed on October 26, 2017 read, "regular." However, physicians orders dated October 26, 2017 read, "Mechanical soft diet heart healthy 1800 calorie Diabetic diet." No clarification order obtained.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future before admission I will verify or clarify all documents required to the Res. primary physician what is the right order before admitting to my facility	5/28/19

	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 response to the following: • November 2017 monthly progress notes – No response to antibiotic medication prescribed on November 22, 2017 • December 2017 monthly progress notes – No response to all medications • March 2018 monthly progress notes – No response to new medication prescribed on March 8, 2018.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	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 response to the following: • November 2017 monthly progress notes – No response to antibiotic medication prescribed on November 22, 2017 • December 2017 monthly progress notes – No response to all medications • March 2018 monthly progress notes – No response to new medication prescribed on March 8, 2018.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** All monthly progress notes will be done correctly & record any response if there's any change in resident's condition or no changes as well. It will be documented immediately of any changes	3/30/19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(4) During residence, records shall include: Entries describing treatments and services rendered; **FINDINGS** Resident #1, monthly progress notes did not document blood sugar testing/results and response to insulin administration.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, a MAR was developed to include the blood sugar testing results. Blood sugar testing was listed on another form. Responses to insulin administration was listed on monthly reviews. Hereafter responses will be listed in progress notes.	2/27/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(4) During residence, records shall include: Entries describing treatments and services rendered; **FINDINGS** Resident #1, monthly progress notes did not document blood sugar testing/results and response to insulin administration.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Everytime I check Blood Sugar testing, I will document it right away on progress notes & the response to insulin administration as well.	3/30/19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(7) During residence, records shall include: Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency; **FINDINGS** Resident #1, admitted November 21, 2017, no weight recorded on the height and weight record for November and December 2017. **This is a repeat deficiency from your 2016 & 2017 annual inspection.**	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(7) During residence, records shall include: Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency; **FINDINGS** Resident #1, admitted November 21, 2017, no weight recorded on the height and weight record for November and December 2017. **This is a repeat deficiency from your 2016 & 2017 annual inspection.**	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future upon admission I'll make a checklist to remind me to take the Ht + Wt ~~on record~~ in I will put the Ht + Wt record on the wall next to the scale to remind me to take their Ht. + Wt. every month.	5/29/19

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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** Resident #1, January 2018 monthly progress note read, "One day she was hallucinating bec. of low sugar." No incident report.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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** Resident #1, January 2018 monthly progress note read, "One day she was hallucinating bec. of low sugar." No incident report.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Every unusual circumstances that occurs on resident's condition like behavior problems, I will make an incident report & report to the doctor immediately.	3/30/19

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APR 0 8 2019

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-19 Resident accounts. (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative. **FINDINGS** Resident #1, admitted on November 21, 2017, no signed financial statement.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes deficiency was corrected, a financial statement was signed 8/14/18	2/27/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-19 Resident accounts. (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative. **FINDINGS** Resident #1, admitted on November 21, 2017, no signed financial statement.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Upon admitting a resident, always check on admission check list so that all required documents be signed by resident like the financial statement, or a legal guardian or family member, & signed by caregiver as well.	3/30/19

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APR 0 8 2019

	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, January 2018 monthly progress note read, "One day she was hallucinating bec. of low sugar." However, no documentation of blood glucose reading, interventions provided and whether the physician or APRN was notified.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	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, January 2018 monthly progress note read, "One day she was hallucinating bec. of low sugar." However, no documentation of blood glucose reading, interventions provided and whether the physician or APRN was notified.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this dificiency I will document any incident accured and make incident report as well as narrative report on Progress note and I will notify the physician + family as well..	5/28/19

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MAY 28 2019

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(1)(A) Residents' rights and responsibilities: Written policies regarding the rights and responsibilities of residents during the stay in the Type I ARCH shall be established and a copy shall be provided to the resident and the resident's family, legal guardian, surrogate, sponsoring agency or representative payee, and to the public upon request. The Type I ARCH policies and procedures shall provide that each individual admitted shall: Be fully informed orally or in writing, prior to or at the time of admission, of these rights and of all rules governing resident conduct. There shall be documentation signed by the resident that this procedure has been carried out; **FINDINGS** Resident #1, admitted on November 21, 2017, no signed general operational policy.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** General operated policy for Resident No. 1 was signed on 8/14/18	2/27/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(1)(A) Residents' rights and responsibilities: Written policies regarding the rights and responsibilities of residents during the stay in the Type I ARCH shall be established and a copy shall be provided to the resident and the resident's family, legal guardian, surrogate, sponsoring agency or representative payee, and to the public upon request. The Type I ARCH policies and procedures shall provide that each individual admitted shall: Be fully informed orally or in writing, prior to or at the time of admission, of these rights and of all rules governing resident conduct. There shall be documentation signed by the resident that this procedure has been carried out; **FINDINGS** Resident #1, admitted on November 21, 2017, no signed general operational policy.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future I will make sure that upon admission the Gen. Operational Policy has been signed by the resident or whoever her authorized to sign. In addition I will go over all the required documents if it is completed in order not to have this differiency again. I will check my admission checklist again in order not to ~~makes~~ miss any document needed for admission	6/24/19

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MAY 29 2019

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(2)(E) Residents' rights and responsibilities: Each resident shall: Be treated with understanding, respect, and full consideration of the resident's dignity and individuality, including privacy in treatment and in care of the resident's personal needs; **FINDINGS** Resident #1, admitted on November 21, 2017, no signed video camera/surveillance policy and procedures.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** It was corrected permit was signed on 8/14/18	2/27/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(2)(E) Residents' rights and responsibilities: Each resident shall: Be treated with understanding, respect, and full consideration of the resident's dignity and individuality, including privacy in treatment and in care of the resident's personal needs; **FINDINGS** Resident #1, admitted on November 21, 2017, no signed video camera/surveillance policy and procedures.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To ensure that this deficiency will not happen again. I will include to my care Home checklist about video Camera/ Surveillance Policy + procedures to be approved + signed by the resident or family. upon admission.	5/28/19

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MAY 28 2019

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-23 Physical environment. (g)(3)(I) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: 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: **FINDINGS** Resident #1, admitted on November 21, 2017, self-preservation statement not indicate self-preservation status.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Self-preservation of Resident I was completed and signed by the physician on 8/18/18	2/27/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-23 Physical environment. (g)(3)(I) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: 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: **FINDINGS** Resident #1, admitted on November 21, 2017, self-preservation statement not indicate self-preservation status.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future upon admission I'll make sure that all required document for admission has been completed as well as signed by the doctor. Also I will check on the admission checklist in order not to miss any document needed for admission	5/29/19

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MAY 29 2019

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-86 Fire safety. (a) A Type I expanded ARCH shall be in compliance with existing fire safety standards for a Type I ARCH, as provided in section 11-100.1-23(b), and the following: **FINDINGS** Fire drills were not specific to the care home and did not follow fire evacuation plan.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** It was corrected - fire drills were specific to the IC/AR CARE HOME & did follow fire evacuation plan	2/27/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-86 Fire safety. (a) A Type I expanded ARCH shall be in compliance with existing fire safety standards for a Type I ARCH, as provided in section 11-100.1-23(b), and the following: **FINDINGS** Fire drills were not specific to the care home and did not follow fire evacuation plan.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this deficiency in the future. I will use my current evacuation plan ~~fire plan~~ during my monthly fire drill on my care home w/ my residents to complete and document the fire drill accurately.	5/28/19

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MAY 28 2019

Licensee's/Administrator's Signature: _____

Print Name: EMELYN A. ILAR

Date: April 8/19

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APR 0 8 2019

Licensee's/Administrator's Signature: _____

Print Name: Emelyn Ilar

Date: 2/27/19

Licensee's/Administrator's Signature: _____

Print Name: Emelyn Ilar

Date: 5/28/19

Licensee's/Administrator's Signature: _____

Print Name: Emelyn Ilar

Date: 5/29/19