

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Ibera, Emerlinda	CHAPTER 100.1
Address: 1631 Kilohana Street, Honolulu, Hawaii 96819	Inspection Date: July 12, 2018 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.

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>§11-100.1-10 <u>Admission policies.</u> (d) The Type I ARCH shall only admit residents at appropriate levels of care. The capacity of the Type I ARCH shall also be limited by this chapter, chapter 321, HRS, and as determined by the department.</p> <p><u>FINDINGS</u> Resident #1 – 8/16/2017 documented level of care by physician = Intermediate Nursing Care Level. ARCH is not licensed for expanded residents.</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>Resident #1: She was taken to the doctor for re-evaluation of her level of care. Level of care for ARCH has been filled now</i></p>	<p style="text-align: center;"><i>8-13-18</i></p>

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<input checked="" type="checkbox"/> §11-100.1-10 <u>Admission policies.</u> (d) The Type I ARCH shall only admit residents at appropriate levels of care. The capacity of the Type I ARCH shall also be limited by this chapter, chapter 321, HRS, and as determined by the department. <u>FINDINGS</u> Resident #1 – 8/16/2017 documented level of care by physician = Intermediate Nursing Care Level. ARCH is not licensed for expanded residents.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>When the resident go for her annual P.E. and her level of care has changed to Intermediate Nursing Care level, I will inform her social worker immediately to refer her to expanded care Facility.</i></p>	<p style="text-align: center;"><i>9-18-18</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p>FINDINGS Resident #1 – No annual tuberculosis clearance.</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>Resident #1 was taken to the doctor to have her tuberculosis assessment and attestation screening form to be filled. Form was filled and completed by the doctor</i></p>	<p><i>8.13-18</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><u>FINDINGS</u> Resident #1 - No annual tuberculosis clearance.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>Together with my substitute three months before scheduled inspection I'll go over the residents records if everything is up to date of all the necessary documents. I will also have a check list of all the things to be done for each resident.</i></p>	<p style="text-align: right;"><i>9-18-18</i></p>

	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><u>FINDINGS</u> Monthly progress notes do not include observations of Resident #1's response to 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;">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	
		PART 1	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> PCG stated she sanitizes dishes once a day instead of after each use.</p>	<p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>I trained all my substitute care-givers to sanitize dishes after each use. A copy of the sanitation guide was given to each.</i></p>	<p><i>7-13-18</i></p>

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Licensee's/Administrator's Signature: Emerlinda L. Ibera

Print Name: Emerlinda L. Ibera

Date: 8-6-2018

Licensee's/Administrator's Signature: Emerlinda Ibera

Print Name: Emerlinda Ibera

Date: Sept 20, 2018