

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Castanaga, Imelda (ARCH/Expanded ARCH)	CHAPTER 100.1
Address: 94-972 Lumimoe Street, Waipahu, Hawaii 96797	Inspection Date: August 8, 2017 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) DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

RECEIVED

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>. (a)(4) No person, group of persons, or entity shall operate an ARCH or expanded ARCH without a license previously obtained under and in compliance with this chapter and chapter 321, HRS.</p> <p>The license issued by the department shall be posted in a conspicuous place visible to the public, on the premises of the ARCH or expanded ARCH;</p> <p><u>FINDINGS</u> Current license received; however, the license was not visible.</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>I have the license right away in a visible place.</i></p>	<p style="text-align: center;"><i>Yes</i></p> <p style="text-align: center;"><i>8/8/17</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>. (a)(4) No person, group of persons, or entity shall operate an ARCH or expanded ARCH without a license previously obtained under and in compliance with this chapter and chapter 321, HRS.</p> <p>The license issued by the department shall be posted in a conspicuous place visible to the public, on the premises of the ARCH or expanded ARCH;</p> <p><u>FINDINGS</u> Current license received; however, the license was not visible.</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>I will make a note to remind myself to hang the license when I received it.</i></p>	<p><i>8/8/17</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> (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 #2, no current physical examination (PE). PEs dated 7/28/16. Repeat citation (2016).</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>I will make and appointment for physical Examination prior to due date. SCG #1 PE was done. SCG #2 she left the care home.</i></p>	<p><i>Yes</i></p> <p><i>8/10/17</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>FINDINGS Substitute care giver (SCG) #1 and #2, no current physical examination (PE). PEs dated 7/28/16. Repeat citation (2016).</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>1) I will check + remind myself that PE done before the due date.</p> <p>2) Mark the date so you can remember before it expires.</p> <p>3) Make an appointment w/ MD</p> <p>4) Give the Substitute Caregiver the PE form to sign by MD.</p> <p>5) File to your binder when its completed.</p>	<p>8/10/17</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><u>FINDINGS</u> SCG #1 and #2, no annual tuberculosis clearance available.</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>SCG #1 TB Test done.</i></p> <p><i>SCG #2 left the care home</i></p>	<p style="text-align: right;"><i>8/9/17</i></p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-12 <u>Emergency care of residents and disaster preparedness.</u> (a)(3) The licensee shall maintain written procedures to follow in an emergency which shall include provisions for the following:</p> <p>Response to disasters which would include evacuation, emergency shelters, and food supply, and as directed by the Civil Defense.</p> <p>FINDINGS Emergency supplies for six (6) persons living in the home does not conform to Civil Defense directives. Repeat citation (2016); i.e. one (1) flat of 500 ml water bottles.</p>	<p>PART 1</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 buy & stock 6 cases of water 500 ml. water bottle for emergency purposes.</i></p>	<p><i>yes</i></p> <p><i>8/10/17</i></p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (1) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.</p> <p><u>FINDINGS</u> First aid box contained one (1) tube of "Triple Antibiotic, expired 1/11".</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>I took out the expired triple antibiotic from the first aid box and discard it right away.</i></p>	<p style="text-align: center;"><i>yes</i></p> <p style="text-align: center;"><i>8/8/17</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (1) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.</p> <p>FINDINGS First aid box contained one (1) tube of "Triple Antibiotic, expired 1/11".</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>1) I will check the First Aid kit monthly that everything is intact.</i></p> <p><i>2) I would say that I do not belong to First Aid kit.</i></p> <p><i>3) Refer to check list.</i></p>	<p style="text-align: right;"><i>8/8/17</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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><u>FINDINGS</u> Resident #1, Physician order dated <u>09/29/16</u> reads, "Vraylar 1.5 mg one tablet at night". However, no initial indicated in the medication administration record (MAR) until <u>10/01/16</u>.</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> <p style="text-align: right;">STATE OF GEORGIA BOSTON, GA STATE LICENSING</p>	<p style="text-align: right;">19 FEB 27 P2:44</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-16 <u>Personal care services.</u> (h) A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed.</p> <p><u>FINDINGS</u> Resident #1, activity schedule does not reflect a reduction in "Club House" activity to Monday, Wednesday, and Friday.</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>Dr. Park order Club House 5X a week but client does not want to go everyday. MD made arrangement w/ client verbally try to attend even 3X a week but MD just to sign. I tell to him everyday to attend Club House or part of his well being.</i></p>	<p style="text-align: center;"><i>Yes</i></p> <p style="text-align: right;"><i>8/9/17</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(4) During residence, records shall include:</p> <p>Entries describing treatments and services rendered;</p> <p><u>FINDINGS</u> Resident #1, physician request dated 3/30/17, "monitor bowel movement-should be every other day" No documentation for the frequency of bowel movements reflected in the record.</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>	<p style="text-align: right;">19 FEB 27 P 2:45</p>

STATE OF CONNECTICUT
 DEPARTMENT OF SOCIAL SERVICES
 100 STATE STREET
 HARTFORD, CT 06103

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	<p>§11-100.1-17 <u>Records and reports. (g)</u> All information contained in the resident's record shall be confidential. Written consent of the resident, or resident's guardian or surrogate, shall be required for the release of information to persons not otherwise authorized to receive it. Records shall be secured against loss, destruction, defacement, tampering, or use by unauthorized persons. There shall be written policies governing access to, duplication of, and release of any information from the resident's record. Records shall be readily accessible and available to authorized department personnel for the purpose of determining compliance with the provisions of this chapter.</p> <p><u>FINDINGS</u> Resident and facility records unsecured on a dining table, in anticipation of the annual inspection. Repeat citation (2016).</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>1) I will put all charts records in a locked up cabinet. 2) Check cabinet often if its locked. 3) Put all records in locked up cabinet after used no its secured.</p>	<p style="text-align: center;"><i>Yes</i></p> <p style="text-align: right;"><i>8/10/17</i></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) 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><u>FINDINGS</u> One (1) exterior door can not be locked. This exterior door is located next to the sink in the resident recreation room. There are two (2) locking devices; however, both locks are broken.</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>my husband fit the door locks. and now its working properly.</i></p>	<p style="text-align: center;"><i>Yes</i></p> <p style="text-align: center;"><i>8/12/17</i></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> (o)(1)(D) Bedrooms:</p> <p>General conditions:</p> <p>Bedrooms shall not be used for recreation, cooking, dining, storage, bathrooms, laundries, foyers, corridors, lanais, and libraries;</p> <p><u>FINDINGS</u> Bedroom #3 licensed by the department, used for storage. Repeat citation (2016).</p> <ol style="list-style-type: none"> 1. Packages of new household items (tablecloths), a bag of clothing, one (1) cane and shoes in room. 2. Numerous boxes and large plastic bags holding bedding fill the closet. 	<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>All packages household items clothing + boxes plastic bags are all taken out & cleared the room. SCG clean the room.</i></p>	<p><i>yes</i></p> <p><i>8/9/17</i></p>

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Licensee's/Administrator's Signature: Imelda B. Castanaga

Print Name: IMELDA B. CASTANAGA

Date: 2/27/19

Licensee's/Administrator's Signature: Imelda B. Castanaga

Print Name: IMELDA B. CASTANAGA

Date: 6/25/19

19 FEB 27 P2:45
STATE OF OHIO
BEN-ORCA
STATE LICENSING

RECEIVED