Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Cachola Adult Residential Care Home	**CHAPTER 100.1**
Address: **98-314 Ponokaulike Street, Aiea, Hawaii 96701**	**Inspection Date: February 2, 2021 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
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** Substitute care giver #1: No documentation of annual physical assessment by a physician. STATE OF HAWAII DOH-OHCA STATE LICENSING	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Physical was done and filed in care home binder.	3/4/21

21 MAR 16 P3:00

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** Substitute care giver #1: No documentation of annual physical assessment by a 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?** I will keep a log of caregivers requirements and write down the expiration dates and when to obtain a new one.	3/4/2021

STATE OF HAWAII
DOH-OHCA
STATE LICENSING

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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 #1: no documented evidence of annual tuberculosis clearance.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Tuberculosis clearance was done and filed in care home binder.	3/4/21

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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 #1: no documented evidence of annual tuberculosis clearance.	**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 keep a log of caregivers requirements and write down the expiration dates and when to obtain a new one.	3/4/2021

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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: complete MD order not transcribed to medication administration record for the following PRN medications: Acetaminophen 325mg tab, take 2 tabs every 4 hours as needed for mild pain, headache, or fever >100.0 F., Max dose of 300mg in 24 hours; and Bisacodyl 10 mg suppository, 1 suppository rectally daily as needed for constipation.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Transcribe complete medications label (Acetaminophen and Bisacodyl) to MAR as directed by doctors order and medication label.	2/3/21

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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: complete MD order not transcribed to medication administration record for the following PRN medications: Acetaminophen 325mg tab, take 2 tabs every 4 hours as needed for mild pain, headache, or fever >100.0 F., Max dose of 300mg in 24 hours; and Bisacodyl 10 mg suppository, 1 suppository rectally daily as needed for constipation.	**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 transcribe PRN medication labels to MAR as directed by doctor and medication label for myself and caregivers to follow.	2/3/21

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Licensee's/Administrator's Signature: Madelaine Cachola

Print Name: Madelaine Cachola

Date: 3/9/21