

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: J. Quinabo ARCH #1	CHAPTER 100.1
Address: 1553 Kaweloka Street, Pearl City, Hawaii 96782	Inspection Date: January 28, 2020 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.

STATE OF HAWAII
DEPARTMENT OF CORRECTIONS
STATE PRINTING

20 JAN 15 PM 2:44

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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. FINDINGS Substitute Care Giver (SCG) #1 – No documented evidence of an annual physical examination.	<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>No correction possible. SCG #1 no longer work for Quinabo ARCH #1 since Feb. 2019.</i></p> <p style="text-align: center;">STATE OF MARYLAND STATE LICENSING</p>	<p style="text-align: center;"><i>2/11/20</i></p> <p style="text-align: center;">20 Feb 19 PM 12:45</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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. <u>FINDINGS</u> Substitute Care Giver (SCG) #1 – No documented evidence of an annual physical examination.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <ol style="list-style-type: none"> 1.) Created a check list. 2.) I will use this check list to remind all caregivers for annual P.E. 3.) I will remove old forms filed from workers who no longer work in the ARCH. <p style="text-align: right;">STATE OF MICHIGAN STATE OF MICHIGAN STATE OF MICHIGAN</p>	<p style="text-align: center;">1/30/20</p> <p style="text-align: right;">20 Jan 15 P12:45</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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. FINDINGS SCG #1 – No documented evidence of an annual tuberculosis clearance.	<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>No correction possible SCG #1 no longer work for Quinako ARCH #1 since Feb. 2019</i></p>	<p style="text-align: center;"><i>1/30/20</i></p>

STATE OF MICHIGAN
 DEPARTMENT OF
 STATE LICENSING

20 Jan 15 PM 2:45

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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. FINDINGS SCG #1 – No documented evidence of an annual tuberculosis clearance.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>1) Created a checklist 2) I will use this checklist to remind all caregivers for annual requirements including TB clearance. 3.) I will remove old forms filed from workers who no longer work in the Arch.</p> <p style="text-align: right; font-size: small;">STATE LICENSING DIVISION 1/30/20</p>	<p style="text-align: center;">1/30/20</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; <u>FINDINGS</u> SCG #1 – No current first aid certification.	<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>No correction possible SCG#1 no longer work for Duinab's MARCH #1 since Feb 2019</i></p>	<p style="text-align: center;"><i>1/30/20</i></p>

STATE OF CONNECTICUT
STATE LICENSING

20 FEB 15 12:45

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; FINDINGS SCG #1 – No current first aid certification.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <ol style="list-style-type: none"> 1.) created a checklist 2) I will use this checklist to remind all caregivers for annual requirements including First Aid recertifications. 3) I will also remove old forms filed from workers who no longer work in The ARCH. <p style="text-align: right;">STATE OF MICHIGAN DEPARTMENT OF STATE LABORING</p>	<p style="text-align: center;">1/30/20</p> <p style="text-align: right;">20 Jan 15 PM 2:45</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall: Be currently certified in cardiopulmonary resuscitation; <u>FINDINGS</u> SCG #1 – No current CPR certification.	<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;">PART 1</p> <p style="text-align: center;"><i>No correction possible SCG#1 no longer works for Quinako EARC#1 since Feb. 2019</i></p> <p style="text-align: center;">STATE LICENSING DEPT. OF HEALTH STAFF</p>	<p style="text-align: center;"><i>1/30/20</i></p> <p style="text-align: center;">20 JAN 15 PM 2:45</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall: Be currently certified in cardiopulmonary resuscitation; FINDINGS SCG #1 – No current CPR certification.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>1.) Created a checklist 2.) I will use this checklist to remind all caregivers for annual requirements including CPR recertifications. 3.) I will also remove old forms filed from workers who no longer work in the ARCH.</p>	<p style="text-align: center;">1/30/20</p>

STATE OF CONNECTICUT

20 APR 15 PM 12:45

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-10 Admission policies. (g) An inventory of all personal items brought into the Type I ARCH by the resident shall be maintained. FINDINGS Resident #1 – No inventory of resident's possessions.	<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.) Carefully inspected and labeled all resident's possessions.</p> <p>2.) Recorded all possessions on the Resident's Valuable Record.</p> <p>3.) Resident's Valuable Record is kept on Resident's chart.</p>	<p style="text-align: center;">1/30/20</p>

STATE OF CONNECTICUT
 DEPARTMENT OF SOCIAL SERVICES

20 JAN 15 PM 2:45

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<input checked="" type="checkbox"/> §11-100.1-10 Admission policies: (g) An inventory of all personal items brought into the Type I ARCH by the resident shall be maintained. <u>FINDINGS</u> Resident #1 – No inventory of resident's possessions.	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>On the day of admission, I will:</i></p> <ol style="list-style-type: none"> <i>1.) Carefully inspect and label all residents' possessions.</i> <i>2.) Record all possessions on Resident's Valuable Record.</i> <i>3.) Keep record on Patient's chart.</i> 	<p style="text-align: center;">1/30/19</p>

STATE OF MICHIGAN
STATE CLERK'S OFFICE

20 APR 15 PM 2:45

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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 – Per resident's medication administration record (MAR), there was an order to discontinue Melatonin on 5/30/2019; however, there's no documented evidence to verify this order.	<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) called doctor's office and verified order to discontinue Melatonin.</p> <p>2) Telephone Order was written down on Physician Notes.</p> <p>3) Faxed Physician Notes to doctor's office for signature.</p> <p>4) Filed document on patient's chart.</p>	<p style="text-align: center;">1/30/20</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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. <u>FINDINGS</u> Resident #1 – Per resident's medication administration record (MAR), there was an order to discontinue Melatonin on 5/30/2019; however, there's no documented evidence to verify this order.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? 1.) I will clarify with PCP all medications ordered upon admission of client to CH. 2) Document on Physician Notes. 3.) Have MD sign Physician Notes on next doctor's appointment.	1/30/20

STATE OF MICHIGAN
 DEPARTMENT OF
 STATE PENSIONS

20 APR 15 12:45

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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. <u>FINDINGS</u> Resident #1 – 5/30/2019 physician's order for Tylenol states, "650 mg, 1 tab orally three times per day." However, the June MAR states, "Tylenol 650 mg, 1 tab orally three times per day as needed for pain." The physician's order did not state "as needed."	<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; font-size: small;">STATE LICENSING STATE OF MARYLAND</p>	<p style="text-align: right;">20 APR 15 PM:45</p>

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STATE OF MARYLAND
DEPARTMENT OF HEALTH
STATE ENGINEERING

20 APR 15 PM 2:45

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 <u>Records and reports.</u> (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; <u>FINDINGS</u> Resident #1 – No annual tuberculosis clearance.	<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 verified again the annual TB form from emailed documents from The Villas.</p> <p>2.) I printed the TB clearance form.</p>	<p style="text-align: center;">1/30/20</p> <p style="text-align: right;">20 Jan 15 PM 2:45</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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STATE OF CONNECTICUT
 DEPARTMENT OF SOCIAL SERVICES
 STATE OF CONNECTICUT

20 Sep 15 PM 2:45

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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 – Monthly progress notes do not include observations of the resident's response to diet or medications.	<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 made a late entry documentation regarding my observations of my resident's response to diet & medications. I indicated ^{stable} patient's w/ and verbalized comfort signifiers that patient is already established in the new home</i></p> <p style="text-align: right;">STAFF SIGNATURE DATE STATE LICENSING</p>	<p style="text-align: center;"><i>1/30/20</i></p> <p style="text-align: center;">20 Jan 15 PM 2:45</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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STATE LIBRARIAN
 20 100 15 PM 04:45

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-83 Personnel and staffing requirements. (5) In addition to the requirements in subchapter 2 and 3: Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents. FINDINGS SCG #1 – 0/12 continuing education hours completed.	<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>No correction possible. SCG#1 no longer work for Quinalba ARCH #1 since Feb. 2019</i></p>	<p style="text-align: center;"><i>1/30/20</i></p>

STATE OF MICHIGAN
 STATE ARCHIVING

20 APR 15 PM 2:45

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-83 Personnel and staffing requirements. (5) In addition to the requirements in subchapter 2 and 3: Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents. <u>FINDINGS</u> SCG #1 – 0/12 continuing education hours completed.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? <i>1 will remove old filed forms from workers who no longer work in the Archl.</i>	1/30/20

STATE OF MICHIGAN
 STATE DEPARTMENT OF
 COMMUNITY SERVICES

20 APR 15 PM 2:45

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-86 Fire safety. (a)(4) 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: Hard wired smoke detectors shall be approved by a nationally recognized testing laboratory and all shall be tested at least monthly to assure working order; FINDINGS Smoke detectors not tested monthly to assure working order.	<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>Smoke detectors has been tested monthly by pressing its button. Composed a new form that status so, and will use that form to document monthly testing of smoke detectors</i></p>	<p style="text-align: center;"><i>1/30/20</i></p>

STATE OF MONTANA
DEPARTMENT OF LABOR

20 009 15 P12:46

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-86 Fire safety. (a)(4) 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: Hard wired smoke detectors shall be approved by a nationally recognized testing laboratory and all shall be tested at least monthly to assure working order; FINDINGS Smoke detectors not tested monthly to assure working order.	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>1) composed a form that status smoke detectors are activated monthly, and form is being used until now.</p> <p>2) Scheduled every 6th of each month to test smoke detectors.</p> <p style="text-align: right;">STATE OF CONNECTICUT STATE DEPARTMENT OF CORRECTIONS</p>	<p style="text-align: center;">1/30/20</p> <p style="text-align: right;">20 APR 15 13:46</p>

Licensee's/Administrator's Signature:

Jessy G. Duin-ABD

Print Name:

JESSY G. DUIN-ABD

Date:

3/17/20

STATE OF CALIFORNIA
STATE LICENSING

20 029 15 PM 2:46