Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Cabico, Milagros (ARCH)	**CHAPTER 100.1**
Address: **94-418 Pilimai Street, Waipahu, Hawaii 96797**	**Inspection Date: July 9, 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
☒	§11-100.1-8 Primary care giver qualifications. (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall: Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current; **FINDINGS** Primary care giver: No documented evidence of six hours of training sessions.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I found the pamphlets for my services since March. Please give me time to answer the questionairs because I can not have certificates if I don't answer the questionairs required for submission. I will submit next week. Since then I have been trained it is now in file	9/a/21

STATE OF HAWAII
STATE LIBRARY

21 SEP -6 P2:57

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-8 Primary care giver qualifications. (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall: Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current; **FINDINGS** Primary care giver: No documented evidence of six hours of training sessi ons.	**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 happen again in the future I will write in the bef. for a reminder so that I that I will not forget.	9/9/21

STATE OF HAWAII
DOH-OCSH
STATE LICENSING

'21 SEP -9 P2:58

	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** Resident #2: 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** obtain but it was misplaced. Found in the family's folder w/ the other papers.	9/9/21

STATE OF HAWAII
DOH-OHCA
STATE LICENSING

21 SEP -9 P2:58

	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** Resident #2: 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?** To avoid this happen again, I will make sure to put all together w/ the important papers. I write a note on my reminder notes so that I will not forget	9/9/21

STATE OF HAWAII
BOARD OF NURSING
STATE LICENSING

21 SEP -9 P2:58

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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** Substitute care giver #1: No documented evidence of cardiopulmonary resuscitation certificate.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Submitting evidence of cpr certificate it was misplaced. I obtain but didn't put where I always can see.	9/9/21

STATE OF HAWAII
BOARD OF
STATE LICENSING

21 SEP -9 P2:58

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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** Substitute care giver #1: No documented evidence of cardiopulmonary resuscitation certificate.	**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 happen again, I will put CPR cards or important papers where I always can see. I will write a reminder on my personal notes.	9/9/21

STATE OF HAWAII
DCH-CHCF
STATE LICENSING

21 SEP -9 P2:58

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year. **FINDINGS** Resident #1: No documented evidence that medication orders were reevaluated every four months or as ordered by physician.	**Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** To avoid this happen again, I will write down in the progress note & the ref. a reminder to re-evaluate medicine every 4 mos.	9/9/21

STATE OF HAWAII
DOH-OHCA
STATE LICENSING

21 SEP -9 P2:58

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year. **FINDINGS** Resident #1: No documented evidence that medication orders were reevaluated every four months or as ordered by 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?** After Telehealth with the doctor I will verify orders with the doctor. I will not forget to write in the progress notes. I will write a reminder on my personal notes STATE OF HAWAII DOH-OHCQ STATE LICENSING '21 SEP -9 P2:58	9/9/21

Licensee's/Administrator's Signature: Milagros Cabico

Print Name: MILAGROS CABICO

Date: 9/9/21

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STATE OF HAWAII
BOH-OFFICE
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