

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Blandina S. Retuta LLC	CHAPTER 100.1
Address: 94-1116 Kahualani Street, Waipahu, Hawaii 96797	Inspection Date: February 19, 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 HEALTH
STATE LABORATORY
20 FEB 27 NO 44

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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 (SCG) #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 style="text-align: center;"><i>Yes, I corrected the deficiency SCG #1 provided current documentation of annual tuberculosis clearance lab result (paperwork included).</i></p>	<p style="text-align: center;"><i>2-24-20</i></p>

STATE OF MARYLAND
 DIVISION OF LICENSING

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<input checked="" type="checkbox"/> §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 (SCG) #1 – No 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>I will thoroughly look through each substitute care givers annual TB clearance and ensure that all documentation is current + approved. I am not aware of the TB Document F: State of Hawaii TB Clearance form. In the future, I will provide this form to all Substitute Care givers + clients to obtain signature by a physician or APRN.</p>	<p style="text-align: right;">2-24-20</p> <p style="text-align: right;">20 FEB 27 AM 4:44</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 – Admission medication order for Lisinopril, Fosamax, Fenofibrate, Ergocalciferol, and Calcium/Vitamin D did not include a dosage.	<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: center;">20 FEB 27 AM 4:45</p>

STATE OF MARYLAND
 DIVISION OF LICENSING

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<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 - Admission medication order for Lisinopril, Fosamax, Fenoibrate, Ergocaliferol, and Calcium/Vitamin D did not include a dosage.	<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>In the future, I will check that all admission medications orders include the medication's dosage. If no dosage is noted, I will follow up with the physicians for correct orders.</p>	<p style="text-align: center;">20 FEB 27 AM 4:45</p>

STATE OF MARYLAND
STATE LICENSING

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 did not include observations of the resident's response to medications.	<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: center;">20 FEB 27 AM 4:5</p>

STATE OF MICHIGAN
DEPARTMENT OF
STATE LICENSING

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 did not include observations of the resident's response to medications.	<p style="text-align: center;">PART 2 <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>Each month, I will thoroughly check and complete my progress notes immediately to include resident's reaction to medication. If there is no reaction, I shall document that resident is "tolerating well." I will also discuss with my substitute care givers his checks for accuracy & completion.</p>	<p style="text-align: right;">2-24-20</p>

Licensee's/Administrator's Signature:

Blanchina A. Keener

Print Name:

BLANCHINA S. KEENER

Date:

2.27-2020

STATE OF MICHIGAN
DEPT. OF LABOR
INDUSTRIAL DIVISION

20 FEB 27 AM 4:5