

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Fabia ARCH EC	CHAPTER 100.1
Address: 94-301 Hilihua Way, Waipahu, Hawaii 96797	Inspection Date: February 17, 2022 Annual Inspection

**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.**

22 MAR -2 P3:31  
STATE OF HAWAII  
DEPARTMENT OF  
STATE LICENSING

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><b><u>FINDINGS</u></b> Resident #1 – Parameters for Senna Laxative 8.6 mg oral tab PO PRN were not included on the medication administration record from 9/2021 to current. “Hold for loose stools”</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>Yes, primary care giver included parameters for senna Laxative 8.6mg oral tab, po PRN to state "Hold for loose stools" on medication Record for Resident #1 - From 09/2021 till current.</p>	<p style="text-align: center;">02/17/22</p> <p style="text-align: right;">22 MAR -2 P 3:31</p> <p style="text-align: right; font-size: small;">STATE OF HAWAII DEPARTMENT OF HEALTH STATE LICENSES</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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><b><u>FINDINGS</u></b> Resident #1 – Activity flow sheet incomplete for 1/2022 and 2/2022.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>primary care giver completed the missing days of the activity flow sheet for 01/2022 and 02/2022.</i></p>	<p style="text-align: center;"><i>02/17/22</i></p> <p style="text-align: right;">22 MAR -2 P3:31</p> <p style="text-align: right; font-size: small;">STATE OF HAWAII DOH-DRCA STATE LICENSING</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(1) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Conduct a comprehensive assessment of the expanded ARCH resident prior to placement in an expanded ARCH, which shall include, but not be limited to, physical, mental, psychological, social and spiritual aspects;</p> <p><b>FINDINGS</b> Resident #1 – No documented evidence of an initial comprehensive assessment completed prior to admission of the resident.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>primary care giver has contacted the case management service for resident's <del>SR</del> #1 and was advised that the (2) page sheet done on their behalf is the case management's standard initial comprehensive assessment form. Advised them of deficiency recieved and that form not up to par with Botlotta.</p>	<p style="text-align: center;">02/17/22</p> <p style="text-align: right;">22 MAR -2 P 3:31</p> <p style="text-align: right; font-size: small;">STATE OF HAWAII DOH-DHCA STATE LICENSING</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(3) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Review the care plan monthly, or sooner as appropriate;</p> <p><b><u>FINDINGS</u></b> Resident #1 – No documented evidence that the care plan was reviewed and updated as needed by the Registered nurse case manager monthly or sooner as appropriate.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;">primary care giver has contacted the case management service for resident #1, and has requested the RN from case management <sup>to be updated</sup> <del>updated</del> and reviews the care plan in chart as needed.</p>	<p style="text-align: center;">02/17/22</p> <p style="text-align: right;">22 MAR -2 P 3:32</p> <p style="text-align: right; font-size: small;">STATE OF HAWAII DOH-ORCA STATE LICENSING</p>



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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(6)            Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Coordinate care giver training, hospital discharge, respite, home transfers and other services as appropriate. Facilitate, advocate and mediate for expanded ARCH residents, care givers and service providers to ensure linkages and provision of quality care for the optimal function of the expanded ARCH resident;</p> <p><b><u>FINDINGS</u></b>            Resident #1 – No documented evidence that RN CM provided Substitute care giver (SCG) #1 delegation training.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>primary caregiver has contacted the casemanagement service and has requested that the RN CM provide SCG#1 delegation training in person as soon as possible.</i></p> <p style="text-align: right; font-size: small;">STATE OF HAWAII DOH-DHCA STATE LICENSING</p>	<p style="text-align: center;"><i>02/17/22</i></p> <p style="text-align: center;"><i>22 MAR -2 P3:32</i></p>

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Licensee's/Administrator's Signature: kyomede

Print Name: KIYSEY YAMADA

Date: 02/17/22

STATE OF HAWAII  
DOH-CHCA  
STATE LICENSING

22 MAR -2 P3:32