

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Hernani T. Valenzuela Aguilar ARCH/EC-ARCH	CHAPTER 100.1
Address: 98-864 Kaamilo Street Aiea, Hawaii 96701	Inspection Date: June 14, 2022 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.

RECEIVED
HHS-OSHA
DIVISION
AUG 23 410:50

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit.</p> <p><u>FINDINGS</u> Resident #1 – No annual diet order signed by physician or APRN available for review.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>The deficiency has been corrected on July 7, 2022 by faxing over request form (diet order) for doctor's approval + signature</i></p>	<p><i>8/10/22</i></p> <p>22 AUG 23 10:50 STATE OF PENNSYLVANIA DH-0466 STATE LMS/OSHS</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit.</p> <p><u>FINDINGS</u> Resident #1 – No annual diet order signed by physician or APRN available for review.</p>	<p>PART 2</p> <p><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>In the future, I will add this documented diet in my existing annual check list and let my SCG double check my work to ensure that everything is completed.</i></p>	<p>8/10/22</p> <p>22 AUG 23 AM 5:00</p> <p>STATE OF CONNECTICUT DEPARTMENT OF HUMAN SERVICES STATE CLERK</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – No physician signed orders for current wound care treatments available for review.</p>	<p>PART 1</p> <p>DID YOU CORRECT THE DEFICIENCY?</p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>The deficiency has been corrected. Sent a request ^{order} form for doctor's order of wound care treatment dated July 7, 2022</i></p>	<p>8/10/22</p> <p>22 AUG 23 AM 5:50</p> <p>STATE OF KANSAS DEPT. OF STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – No physician signed orders for current wound care treatments available for review.</p>	<p>PART 2</p> <p><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>In the future, I will put a reminder (post it) on Progress Notes for me to remember and add also to my check list.</i></p>	<p><i>8/10/22</i></p> <p>22 AUG 23 AM 5:50</p> <p>STATE OF CONNECTICUT NOTARY PUBLIC STEWART M. BROWN</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p><u>FINDINGS</u> Resident #1 – Medications are not being reviewed and renewed every four months.</p>	<p>PART 1</p> <p>DID YOU CORRECT THE DEFICIENCY?</p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>The last re-evaluation of the medications by the physician was signed on 5/11/22. However, the next review & renewal will be Sept. 2022.</i></p>	<p><i>8/10/22</i></p> <p>22 AUG 23 410:50</p> <p>STATE OF NEW YORK DEPARTMENT OF STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p><u>FINDINGS</u> Resident #1 – Medications are not being reviewed and renewed every four months.</p>	<p>PART 2</p> <p><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>In the future, I will make a 8/10/22 note on my calendar as a reminder to review & renew orders of medications only signed by the Physician or APRN.</i></p>	<p>22 AUG 23 AM 5:0</p> <p>STATE OF ALABAMA BOA-CHIEF STATE/CLINICAL</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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:</p> <p>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;</p> <p><u>FINDINGS</u> Resident #1 – No current diagnosis obtained within the previous twelve months.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">DID YOU CORRECT THE DEFICIENCY?</p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>Sent renewal / re-evaluation of diagnosis to PCP for signature 8/10/22 on August 10, 2022.</i></p>	<p style="text-align: right;">22 AUG 23 AM 50</p> <p style="text-align: right; transform: rotate(-90deg);">STATE OF ILLINOIS DEPARTMENT OF HEALTH STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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:</p> <p>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;</p> <p><u>FINDINGS</u> Resident #1 – No current diagnosis obtained within the previous twelve months.</p>	<p>PART 2</p> <p><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>In the future, I will use the calendar as a reminder for renewal yearly or as needed.</i></p>	<p><i>8/10/22</i></p> <p>22 AUG 23 10:50</p> <p>STATE OF NEW YORK DEPARTMENT OF HEALTH STATE PRISON</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><u>FINDINGS</u> Resident #1 – No current annual tuberculosis clearance available for review.</p>	<p>PART 1</p> <p>DID YOU CORRECT THE DEFICIENCY?</p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>The deficiency has been corrected TB clearance done 6/20/22 Reading - Negative.</i></p>	<p><i>8/10/22</i></p> <p>22 AUG 23 AM 5:00 STATE OF MA DOH-CRHA STATE/CRH/CRH/CRH</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><u>FINDINGS</u> Resident #1 – No current annual tuberculosis clearance available for review.</p>	<p>PART 2</p> <p><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>In the future, I will ^{use} check list/ calendars as a reminder for renewal annually.</i></p>	<p><i>8/16/22</i></p> <p>22 AUG 23 AM 50</p> <p>STATE OF NEW YORK CORRECTIONAL SYSTEMS</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><u>FINDINGS</u> Resident #1 - No current annual physical exam available for review.</p>	<p>PART 1</p> <p>DID YOU CORRECT THE DEFICIENCY?</p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Sent Annual Physical Exam to PCP for evaluation — signature on Aug. 10, 2022.</i></p>	<p><i>8/10/22</i></p> <p>22 AUG 23 AM 50</p> <p>STATE OF HAWAII DOH-06/22 STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><u>FINDINGS</u> Resident #1 - No current annual physical exam available for review.</p>	<p>PART 2</p> <p><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>In the future, I will use my check list as a reminder for renewal annually.</i></p>	<p>8/10/22</p> <p>22 AUG 23 AM 50</p> <p>STATE OF CONNECTICUT DEPARTMENT OF STATE CORRECTIONS</p>

	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><u>FINDINGS</u> Resident #1 - Bowel movements are not being documented as described in the RN Care Manager's care plan for Constipation which says, "Document all BM's in patient's chart".</p>	<p>PART 1</p> <p>DID YOU CORRECT THE DEFICIENCY?</p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>The CM deleted "Document all BM's patient's chart from constipation careplan on 7/27/22.</p>	<p>8/10/22 K</p> <p>22 AUG 23 AM 0:50</p> <p>STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES STATE LICENSING</p>

	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><u>FINDINGS</u> Resident #1 - Bowel movements are not being documented as described in the RN Care Manager's care plan for Constipation which says, "Document all BM's in patient's chart".</p>	<p>PART 2</p> <p><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>In the future, I will indicate bowel movement by putting checkmark (✓) on MAR on a daily basis.</i></p>	<p><i>8/10/22</i></p> <p>22 AUG 23 4:05:00</p> <p>STATE CLERKING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary.</p> <p>FINDINGS Resident #1 – No incident report for emergency room visit on 8/9/21.</p>	<p>PART 1</p> <p>DID YOU CORRECT THE DEFICIENCY?</p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>IT was noted on the progress Notes. However NO incident report form completed but protocol of calling / notifying MO, family, guardian is completed.</i></p>	<p>22 AUG 23 10:50</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary.</p> <p><u>FINDINGS</u> Resident #1 – No incident report for emergency room visit on 8/9/21.</p>	<p>PART 2</p> <p><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>In the future, I will ask the substitute care givers to remind me to complete the Incident Report Form.</i></p>	<p><i>8/10/22</i></p> <p>22 AUG 23 110:50</p> <p>STATE OF HAWAII DEPARTMENT OF HEALTH STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-19 <u>Resident accounts.</u> (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative.</p> <p>FINDINGS Resident #1 – Financial statement not signed by resident's guardian.</p>	<p>PART 1</p> <p>DID YOU CORRECT THE DEFICIENCY?</p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>I have corrected this deficiency by sending the form to the guardian on August 10, 2022 for signature.</i></p>	<p><i>8/10/22</i></p> <p>22 AUG 23 AM 5:51</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-19 <u>Resident accounts.</u> (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative.</p> <p><u>FINDINGS</u> Resident #1 – Financial statement not signed by resident's guardian.</p>	<p>PART 2</p> <p><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>In the future, I will double check all documents/paper works on my check list of any missing signatures upon admission.</i></p>	<p>8/18/22</p> <p>22 AUG 23 MON 51</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
	<p>§11-100.1-87 <u>Personal care services.</u> (c)(3) The primary care giver shall, in coordination with the case manager, make arrangements for each expanded ARCH resident to have:</p> <p>Visits to the physician every four months or more frequently to ensure adequate medical supervision.</p> <p><u>FINDINGS</u> Resident #1 – Resident is not meeting with their physician every four months.</p>	<p>PART 1</p> <p>DID YOU CORRECT THE DEFICIENCY?</p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>I have called doctor's office for appointment with PCP for Sept 16, 2022 thru video call.</i></p>	<p><i>8/18/22</i></p> <p>STATE OF HAWAII DEPT. OF HEALTH STATE LIC. DIV. 22 AUG 23 AM 5:51</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
	<p>§11-100.1-87 <u>Personal care services.</u> (c)(3) The primary care giver shall, in coordination with the case manager, make arrangements for each expanded ARCH resident to have:</p> <p>Visits to the physician every four months or more frequently to ensure adequate medical supervision.</p> <p><u>FINDINGS</u> Resident #1 – Resident is not meeting with their physician every four months.</p>	<p>PART 2</p> <p><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>In the future, I will use calendars 8/18/22 as a reminder to set up future appointments with PCP every 4 months.</i></p>	<p>22 AUG 23 AM 05:1</p> <p>STATE CLERK JULIA A. BROWN STATE CLERK</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
	<p>§11-100.1-87 <u>Personal care services</u>. (c)(2) The primary care giver shall, in coordination with the case manager, make arrangements for each expanded ARCH resident to have:</p> <p>Pneumococcal and influenza vaccines and any necessary immunizations following the recommendations of the Advisory Committee of Immunization Practices (ACIP);</p> <p><u>FINDINGS</u> Resident #1 – does not have a current annual flu shot nor is there documentation from the guardian prohibiting resident from getting annual flu shots or other vaccinations.</p>	<p>PART 1</p> <p>DID YOU CORRECT THE DEFICIENCY?</p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>This deficiency has been corrected, resident had the annual flu shot on 6/17/22</i></p>	<p><i>8/18/22</i></p> <p>22 AUG 23 10:51</p> <p>STATE OF MICHIGAN HHS-2203A STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
	<p>§11-100.1-87 <u>Personal care services.</u> (c)(2) The primary care giver shall, in coordination with the case manager, make arrangements for each expanded ARCH resident to have:</p> <p>Pneumococcal and influenza vaccines and any necessary immunizations following the recommendations of the Advisory Committee of Immunization Practices (ACIP);</p> <p><u>FINDINGS</u> Resident #1 – does not have a current annual flu shot nor is there documentation from the guardian prohibiting resident from getting annual flu shots or other vaccinations.</p>	<p>PART 2</p> <p><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>In the future, I will use my check lists as a reminder for any annual refirements as recommended by Health Advisory Committee.</i></p>	<p><i>8/18/22</i></p> <p>22 AUG 23 AM 5:1</p> <p>STATE OF HAWAII DEPARTMENT OF HEALTH STATE LICENSING</p>

Licensee's/Administrator's Signature: Dem T. Uke

Print Name: HERNANI AGUILAN

Date: 8/18/22

22 AUG 23 AM 5:1
STATE OF HAWAII
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STATE LICENSING