

## Office of Health Care Assurance

## State Licensing Section

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

Facility's Name: Lusitana	CHAPTER 100.1
Address: 1925 Lusitana Street, Honolulu, Hawaii 96813	Inspection Date: July 8, 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) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

STATE OF HAWAII  
OFFICE OF HEALTH CARE ASSURANCE  
LICENSING SECTION

22 SEP -6 4 8:18

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p><u>FINDINGS</u> Housekeeper #1 – No documented evidence of annual physical exam. Submit a copy with plan of correction.</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>Housekeeper #1 had an appointment with MD for her physical exam on 9/07/2022.</i></p>	<p><i>7/20/22</i></p> <p>STATE OF HAWAII DEPARTMENT OF HEALTH STANDARD 100.1-9</p>

22 AUG -9 08:32

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p><u>FINDINGS</u> Housekeeper #1 – No documented evidence of annual physical exam. Submit a copy with plan of correction.</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>In the future, I will make a checklist of the requirements for the housekeeper that includes annual physical exam. I will put in my calendar their due dates. I'll keep track with my calendar, check it at least once a month.</p>	<p>8/31/22</p> <p>22 SEP -6 18:18</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p><b><u>FINDINGS</u></b> Housekeeper #1 No documented evidence of an initial or annual tuberculosis clearance. Submit a copy with plan of correction.</p>	<p>PART 1</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Housekeeper #1 had an appointment with MD for her TB clearance on 9/07/2022.</i></p>	<p><i>7/10/22</i></p> <p>STATE OF MICHIGAN DEPARTMENT OF COMMUNITY CARE 2022 AUG -9 10:32</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p><b><u>FINDINGS</u></b> Housekeeper #1 - No documented evidence of an initial or annual tuberculosis clearance. Submit a copy with plan of correction.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future, I will make a checklist of <sup>all</sup> the requirements for the housekeeper that includes initial or annual TB clearance. I will put in my calendar their due dates. I'll keep track with my calendar, <del>the</del> check it at least once a month.</p>	<p>8/31/22</p> <p style="text-align: right;">22 SEP -6 10:18</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 #3 – Medications due at 7:00am were found in medication cabinet in a medication cup not yet administered at 10:00am, 3 hours past due.</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>The medications were given to Resident #3 while the surgeons were still in my care home. He was asleep but I had to wake him up.</p>	<p>7/08/22</p> <p>22 AUG -9 18:32</p> <p>STATE OF MICHIGAN PORTLAND 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 #3 – Medications due at 7:00am were found in medication cabinet in a medication cup not yet administered at 10:00am, 3 hours past due.</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>I will make a reminder note, "Give meds at the right time!" and post it by the medicine cabinet to remind me and my staff to administer medications timely.</i></p>	<p>8/31/22</p> <p>22 SEP - 6 AM '8</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><b>FINDINGS</b> Resident #1 – Physician’s order dated 9/22/21 states, “Eliquis 2.5mg tab. Take 1 tab by mouth once a day”; however, medication documented as given twice a day on medication administration record (MAR) between 9/22/21-1/26/22.</p>	<p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p>STATE OF MARYLAND DEPARTMENT OF STATE LICENSING</p>

22 AUG -9 A9:13



	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (c) 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 – Physician's order dated 9/22/21 states, "Eliquis 2.5mg tab. Take 1 tab by mouth once a day"; however, medication documented as given twice a day on medication administration record (MAR) between 9/22/21-1/26/22.</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>I will make a reminder note, ① check written MD orders before leaving the office; ② check MD orders against MAR when I'll get home." stick or clip it in my folder and bring it with me on the residents appointment. I'll copy the reminder note, stick it on the refrigerator for me and my staff to be reminded.</i></p>	<p><i>8/31/22</i></p> <p>22 SEP - 6 AM '18</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><b>FINDINGS</b> Resident #1 – Physician's order dated 9/22/21 states, "Aciphex 20mg tab. Take 1 tab by mouth twice a day"; however, medication documented as given once a day on MAR between 9/22/21-1/26/22.</p>	<p>PART I</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p>22 AUG -9 A9:13</p> <p>STATE OF HAWAII DEPARTMENT OF CORRECTIONS</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><b><u>FINDINGS</u></b> Resident #1 – Physician's order dated 9/22/21 states, "Aciphex 20mg tab. Take 1 tab by mouth twice a day"; however, medication documented as given once a day on MAR between 9/22/21-1/26/22.</p>	<p>PART 2</p> <p><b><u>FUTURE PLAN</u></b></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>I will make a reminder note, "① check written MD orders before leaving the office, ② check MD orders against MAR when I'll get home!", stick or clip it on my folder and bring it with me on residents' appointment. I'll copy the reminder note, stick it on the refrigerator for me and my staff to be reminded.</i></p>	<p>8/31/22</p> <p>22 SEP - 6 18:18</p>

	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>FINDINGS</b> Resident #3 – Physician ordered “Thick-It” for nectar thickened liquids, however, Thick-It not included on MAR. No documented evidence thickener is being used.</p>	<p>PART 1</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>The thickener "Thick It" been included on the residents MAR</i></p>	<p><i>7/08/22</i></p> <p>22 AUG -9 09:13</p> <p>STATE OF HAWAII STATE DEPARTMENT OF HEALTH</p>

	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><u>FINDINGS</u> Resident #13 – Physician ordered "Thick-It" for nectar thickened liquids, however, Thick-It not included on MAR. No documented evidence thickener is being used.</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>I will make a reminder note, to "include/add "Thick It" to the MAR" and stick it on the refrigerator/conspicuous space to remind me and my staff to do this.</i></p>	<p><i>8/31/22</i></p> <p>22 SEP -6 48:18</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (f)(4) General rules regarding records:</p> <p>All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency.</p> <p><b>FINDINGS</b> Resident #1 -- Resident emergency information sheet does not reflect resident's current diagnoses. Submit updated copy with plan of correction.</p>	<p>PART 1</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>Resident's emergency information been updated with the current diagnosis.</i></p>	<p>7/08/22</p> <p>22 AUG -9 09:13</p> <p>STATE OF HAWAII DOH-DCA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (f)(4) General rules regarding records:</p> <p>All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency.</p> <p><b><u>FINDINGS</u></b> Resident #1 – Resident emergency information sheet does not reflect resident's current diagnoses. Submit updated copy with plan of correction.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>I will use a checklist of the things to be done daily, to include update residents' emergency information sheet when diagnoses are changed or added. I will refer to my checklist everyday to make sure all tasks are completed.</i></p>	<p><i>8/31/22</i></p> <p style="text-align: right;">22 SEP -6 18:18</p>



	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 Physical environment. (h) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p><b>FINDINGS</b> Bedroom #3 – Mud/paper on wall in bedroom peeling and cracking</p>	<p>PART I</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>The wall in bedroom #3 been fixed with <del>mud</del><sup>new</sup> mud.</i></p>	<p>7/22/22</p> <p>22 AUG -9 09:13</p> <p>STATE OF HAWAII DEPARTMENT OF STATE PLANNING</p>



	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (h) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p><b>FINDINGS</b> Bedroom #3 – Mud/paper on wall in bedroom peeling and cracking</p>	<p align="center"><b>PART 2</b></p> <p align="center"><b><u>FUTURE PLAN</u></b></p> <p align="center"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future, I will check all the bedrooms on a daily basis to make sure that the safety of the facility is being maintained. I will ask my SCBA to do the same as well. I will post the reminder to check the rooms daily by the refrigerator.</p>	<p align="right">7/22/22</p> <p align="right">22 AUG -9 09:13</p> <p align="right">STATE OF HAWAII DEPT. OF CORRECTIONS JAIL LIBRARY</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (b)(1)(A) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p>Housekeeping:</p> <p>A plan including but not limited to sweeping, dusting, mopping, vacuuming, waxing, sanitizing, removal of odors and cleaning of windows and screens shall be made and implemented for routine periodic cleaning of the entire Type I ARCH and premises;</p> <p><u>FINDINGS</u> Bedroom #5 and adjacent bathroom – Foul odors present</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>I took the trash out, cleaned and sanitized the bathroom and the bedroom #5 right after the residents done using the bathroom/ made BM, while the surveyors were still in my care home.</i></p>	<p><i>7/08/22</i></p> <p>22 AUG -9 09:13</p> <p>STATE OF HAWAII DOH-CHS STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§ 11-100.1-23 <u>Physical environment.</u> (h)(1)(A) The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p>Housekeeping:</p> <p>A plan including but not limited to sweeping, dusting, mopping, vacuuming, waxing, sanitizing, removal of odors and cleaning of windows and screens shall be made and implemented for routine periodic cleaning of the entire Type I ARCH and premises;</p> <p><b><u>FINDINGS</u></b> Bedroom #5 and adjacent bathroom – Foul odors present</p>	<p>PART 2</p> <p><b><u>FUTURE PLAN</u></b></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>I will use a checklist of the things to be done daily. to include clean and sanitize the residents' bathrooms and bedrooms timely. I will refer to my checklist everyday to make sure all tasks are completed.</i></p>	<p><i>8/31/22</i></p> <p>22 SEP -6 48:18</p> <p>STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES HARTFORD, CT 06103</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment, (j)(1)</u> Waste disposal:</p> <p>Every Type I ARCH shall provide a sufficient number of watertight receptacles, acceptable to the department for rubbish, garbage, refuse, and other matter. These receptacles shall be kept closed by tight fitting covers;</p> <p><b>FINDINGS</b> Tight fitting covers on receptacles unavailable in bedrooms and bathrooms</p>	<p>PART 1</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>Tight fitting covers on receptacles made available in bedrooms and bathrooms.</i></p>	<p><i>7/20/22</i></p> <p>22 AUG -9 A9:14</p> <p>STATE OF HAWAII DOH STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment</u>, (j)(1) Waste disposal:</p> <p>Every Type I ARCH shall provide a sufficient number of watertight receptacles, acceptable to the department for rubbish, garbage, refuse, and other matter. These receptacles shall be kept closed by tight fitting covers;</p> <p><b><u>FINDINGS</u></b> Tight fitting covers on receptacles unavailable in bedrooms and bathrooms</p>	<p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>I will use a checklist of the things to be done daily, to include, use receptacles with tight fitted lids in bedrooms and bathrooms. I will refer to my checklist everyday to make sure all tasks are done.</i></p>	<p><i>8/31/22</i></p> <p>22 SEP -6 18:18</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-87 <u>Personal care services.</u> (a) The primary care giver shall provide daily personal care and specialized care to an expanded ARCH resident as indicated in the care plan. The care plan shall be developed as stipulated in section 11-100.1-2 and updated as changes occur in the expanded ARCH resident's care needs and required services or interventions.</p> <p><u>FINDINGS</u> Resident #1 – Care plan states, "check incontinence pad every 2 hours and as needed"; however, no documented evidence this task is being performed.</p> <p>Resident #1 – Care plan states, "bring patient to the bathroom every 2 hours during the day and allow patient at least 10 minutes to sit on toilet"; however, no documented evidence task is being performed.</p>	<p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p>22 AUG -9 09:14</p> <p>STATE OF MARYLAND DEPARTMENT OF STATE SERVICES</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-87 <u>Personal care services.</u>(a) The primary care giver shall provide daily personal care and specialized care to an expanded ARCH resident as indicated in the care plan. The care plan shall be developed as stipulated in section 11-100.1-2 and updated as changes occur in the expanded ARCH resident's care needs and required services or interventions.</p> <p><u>FINDINGS</u> Resident #1 Care plan states, "check incontinence pad every 2 hours and as needed"; however, no documented evidence this task is being performed.</p> <p>Resident #1 – Care plan states, "bring patient to the bathroom every 2 hours during the day and allow patient at least 10 minutes to sit on toilet"; however, no documented evidence task is being performed.</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 resident's case manager to update/review the care plans according to the resident's care or as changes occur in the resident's care, with the caregivers.</i></p>	<p><i>7/28/22</i></p> <p>STATE OF MICHIGAN DEPT. OF HUMAN SERVICES STATE LIAISON</p> <p>22 AUG -9 09:14</p>

	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><u>FINDINGS</u>            Resident #1, Substitute Caregiver (SCG) #1 – Case manager training on nurse delegation, insulin pen use, diabetic care, eye drop administration, and cream and ointment application, was not provided or completed by SCG #1, who provides care to the resident.</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>Case manager training on nurse delegation, insulin pen use, diabetic care, eye drop administration, and cream and ointment application was provided and completed by SCG#1. Apparently, SCG#1 didn't sign the training on nurse delegation. SCG#1 signed the training on nurse delegation.</i></p>	<p><i>7/11/2022</i></p> <p>22 AUG -9 19:14</p> <p>STATE OF NEW YORK            DEPARTMENT OF            HEALTH            OFFICE OF LICENSING</p>



	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, Substitute Caregiver (SCG) #1 – Case manager training on nurse delegation, insulin pen use, diabetic care, eye drop administration, and cream and ointment application, was not provided or completed by SCG #1, who provides care to the resident.</p>	<p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>I will make a reminder note, "caregivers to sign all the trainings on nurse delegation" and stick it on the resident's binder.</i></p> <p><i>I will ask my caregivers and case manager to double check the trainings to make sure that all are signed.</i></p>	<p><i>8/31/22</i></p> <p>22 SEP -6 18:18</p>

Licensee's/Administrator's Signature: Carolyn  
Print Name: ~~EAR~~ CAROLYN DE GUZMAN  
Date: 7/30/2022

STATE OF HAWAII  
HONOLULU  
STATE LICENSING

22 AUG -9 A 9:14

Licensee's/Administrator's Signature: Carolyn De Guzman  
Print Name: CAROLYN DE GUZMAN  
Date: 8/31/2022

STATE OF CALIFORNIA  
OFFICE OF THE  
STATE REGISTRAR

'22 SEP -6 A8:18