

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Elisa Cabal (ARCH/Expanded ARCH)	CHAPTER 100.1
Address: 228 Hookano Street, Hilo, Hawaii 96720	Inspection Date: October 10, 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.

	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>FINDINGS Substitute care giver (SCG) #4 – no current annual physical examination. <u>Please submit documentation with your plan of correction.</u></p>	<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 obtain an annual Physical exam from my substitute. I filed it in my care home folder</i></p>	<p style="text-align: center;"><i>12/9/22</i></p>

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<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><u>FINDINGS</u> SCG #2 & SCG #3, no current tuberculosis (TB) clearance. <u>Please submit documentation with your plan of correction.</u></p>	<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 obtain a physician TB test for my substitute copy attached. and file it in my care home folder.</i> </p>	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p><u>FINDINGS</u> SCG #1 – no first aid training. <u>Please submit documentation with your plan of correction.</u></p>	<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>Yes, I already obtain a copy from my substitute. See attached I'm an going to file it in my cca home folder.</p>	<p>12/9/22</p>

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	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 – physician order dated 04-08-22 & 05-27-22 read, “Furosemide 20 mg QD prn edema.” However, April 2022 – current (October 2022) medication record read, “Furosemide <u>10</u> mg 1 tab QD PRN”</p>	<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 already corrected my medication record. to read Furosemide 20mg once a day. PRN</i></p>	<p style="text-align: center;"><i>12/9/22</i></p>

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<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 #1 – physician order dated 02-15-22 and February – April 2022 medication record read, “Stool Softener take 2 tabs daily PRN” However, order did not clearly indicate name of stool softener or dosage (mg).</p>	<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>	

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Licensee's/Administrator's Signature: EVISA COBAL

Print Name: EVISA COBAL

Date: 12/9/22