

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name: Aida's (ARCH/Expanded ARCH)</b>	<b>CHAPTER 100.1</b>
<b>Address: 45-552 Liula Street, Kaneohe, Hawaii 96744</b>	<b>Inspection Date: Novebmer 22, 2022 Annual</b>

**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.**

	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>, (b)(1)(I) Application.</p> <p>In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application:</p> <p>Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law;</p> <p><b><u>FINDINGS</u></b>  Primary Care Giver (PCG), Substitute Care Giver (SCG) #1 &amp; Household Member (HM) #1– No current documented evidence stating aforementioned care givers have no prior felony or abuse convictions in a court of law.</p> <p><b>Please provide a copy of the Fieldprint results with your plan of correction.</b></p>	<p><b>PART 1</b></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>	

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<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 – Ensure bottle observed to be offered to resident during annual visit. No documented evidence of a physician order for Ensure formula. Per PCG, Ensure formula given once daily since last year.</p>	<p><b>PART 1</b></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>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver.</p> <p><b><u>FINDINGS</u></b> Resident #1 - Ensure bottle observed to be offered to resident during annual visit. No record of ensure formula in medication sheet. Per PCG, Ensure formula given once daily since last year.</p>	<p><b>PART 1</b></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>	

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☒	<p>§11-100.1-17 <u>Records and reports.</u> (b)(5) During residence, records shall include:</p> <p>Entries detailing all medications administered or made available;</p> <p><b><u>FINDINGS</u></b> Resident #1 - Physician order for “Tylenol 500mg oral tab. 1 tab by mouth three time a day daily as needed for fever or pain.” As needed (PRN) medication signed as administered three times a day, daily from February 1, 2022 till present. However no documented evidence of reason for taking medication as well as response to medication.</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>	

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<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 – Case Management Plan of Care intervention for Hypertension dated 3/13/22 and signed as reviewed every month thereafter states “ Check B/P daily and as needed; call CM or MD if SBP &gt; 180 and DBP &lt;90 mmHg”, However, on the blood pressure monitoring sheet provided by the case manager; instructions state: “When to notify RN Case Manager or MD: if Systolic BP &gt;180&lt;90, Diastolic BP &gt;90-100. Care plan and blood pressure monitoring flow sheet instructions are inconsistent with each other.</p>	<p><b>PART 1</b></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>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(I) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either:</p> <p><b><u>FINDINGS</u></b> Resident #1 – Annual physical assessment by physician dated 8/23/22 has certified resident as self-preserving, however it was observed that resident is wheelchair dependent during annual visit. Per PCG resident requires partial to full assistance with transferring and resident is “mostly blind.”</p> <p><b>Please clarify with physician and provide an updated self-preservation.</b></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>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(4)            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>Update the care plan as changes occur in the expanded ARCH resident care needs, services and/or interventions;</p> <p><b><u>FINDINGS</u></b>            Resident #1 – Care plan interventions for hypertension were not updated to reflect instructions provided on the flowsheet regarding blood pressure monitoring. Care plan states: “Check B/P daily and as needed; call CM or MD if SBP &gt; 180 and DBP &lt;90 mmHg”, however blood pressure monitoring sheet provided by case manager states “When to notify RN Case Manager or MD: if Systolic BP &gt;180&lt;90, Diastolic BP &gt;90-100. <b>Please clarify with RN Case Manager.</b>”</p>	<p><b>PART 1</b></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>	

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Licensee's/Administrator's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_