Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Santos, Norma (ARCH)	**CHAPTER 100.1**
Address: **4240 Keaka Street, Honolulu, Hawaii 96818**	**Inspection Date: October 27, 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.

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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. **<u>FINDINGS</u>** Substitute Caregiver (SCG) #1,2 – Initial 2-step tuberculosis clearance unavailable for review. Submit a copy with plan of correction.	**PART 1** **<u>DID YOU CORRECT THE DEFICIENCY?</u>** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Substitute Caregiver (SCG) #1 and #2 is complete. Tuberculosis clearance for SCG#1 was completed on 11/7/2022. A copy of TB clearance is attached for your review. Substitute Caregiver (SCG) #2 tuberculosis clearance was completed on 12/5/2022. A copy of TB clearance is attached for your review.	11/7/22 12/5/22

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☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** Substitute Caregiver (SCG) #1,2 – Initial 2-step tuberculosis clearance unavailable for review. Submit a copy with plan of correction.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To prevent future deficiencies, a checklist will be utilized to ensure that documented evidence of TB clearances for substitute caregivers are kept in the Adult Residential Care Home folder and made available for review. All TB clearances shall be done annually as required by Dept of Health. A reminder to complete TB testing will be sent to substitute caregivers prior to expiration.	11/7/22

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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. **<u>FINDINGS</u>** Resident #1 – Physician's order dated 3/21/22 states, "prescribed ibuprofen 600mg today (3/21/22) 15 tabs"; however, order is incomplete and does not include frequency and reason for administration.	**PART 1** **<u>DID YOU CORRECT THE DEFICIENCY?</u>** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Deficiency was corrected by contacting the physician to verify the frequency and reason for administering the prescribed medication to resident. A physician order was obtained, filed in resident's folder, and made available for review.	10/28/22 '22 DEC 19 PM2:13 STATE OF HAWAII DOH-OHCA STATE LICENSING

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Physician's order dated 3/21/22 states, "prescribed ibuprofen 600mg today (3/21/22) 15 tabs"; however, order is incomplete and does not include frequency and reason for administration.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To prevent future deficiencies, a checklist will be utilized to ensure that all physician orders for medications are complete, obtained, filed in resident's folder, and made available for review. The physician order shall include the drug name, dosage, route, frequency and reason for administering the prescribed medication. The physician will be contacted if further verification is needed. Any changes or updates will be documented in resident's record.	10/28/22

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Licensee's/Administrator's Signature: [signature]

Print Name: NORMA Santos

Date: 12/5/22

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