

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Pleasant Valley Type I EARCH	CHAPTER 100.1
Address: 1573 Kilohana Street, Honolulu, Hawaii 96813	Inspection Date: March 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) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

STATE OF HAWAII
EDUCATION
STATE DEPARTMENT

22 MAR 31 PM 2:23

	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><u>FINDINGS</u> Substitute care giver (SCG) #1 - No screening for symptoms consistent with pulmonary tuberculosis (TB). Submit a copy with the plan of correction (POC).</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>PCG OBTAINED A COPY OF SCG#1 TB SCREENING FOR SYMPTOMS CONSISTENT WITH PULMONARY TUBERCULOSIS. COPY ATTACHED</p>	<p style="text-align: right;">03/09/22</p>

RECEIVED

	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><u>FINDINGS</u> Substitute care giver (SCG) #1 - No screening for symptoms consistent with pulmonary tuberculosis (TB). Submit a copy with the plan of correction (POC).</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>PCG CREATED A CHECKLIST TO MONITOR PE, TB CLEARANCES & FINGERPRINTS EXPIRATION DATES MONTHLY. PCG WILL REVIEW THE CHECKLIST MONTHLY AND NOTIFY CG WHEN UPDATES ARE NEEDED</p>	<p style="text-align: right;">06/23/22</p>

RECEIVED

	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><u>FINDINGS</u> SCG #2 - No documented evidence of positive TB clearance. Submit a copy with the POC.</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>PCG OBTAINED A COPY OF SCG#2'S EVIDENCE OF POSITIVE TB CLEARANCE. A COPY IS ATTACHED</i></p>	<p style="text-align: center;"><i>06/23/22</i></p>

RECEIVED

JUN 23 2022

	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><u>FINDINGS</u> SCG #2 - No documented evidence of positive TB clearance. Submit a copy with the POC.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>PCG CREATED A CHECKLIST TO MONITOR PE, TB CLEARANCES & FINGER PRINTS EXPIRATION DATES MONTHLY. PCG WILL REVIEW THE CHECKLIST MONTHLY AND NOTIFY CG WHEN UPDATES ARE NEEDED</p>	<p style="text-align: center;">06/23/22</p>

RECEIVED

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (a) Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be obtained prior to a resident's admission to a Type I ARCH and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's responsible placement agency, and others authorized by the resident to review it.</p> <p><u>FINDINGS</u> Resident #1 - No level of care prior to admission on 10/17/21. The level of care was completed on 10/22/21.</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>	<p style="text-align: right;">22 MAR 31 12:23</p> <p style="text-align: right; font-size: small;">STATE OF HAWAII DOH-OHCA STATE INSURANCE</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (a) Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be obtained prior to a resident's admission to a Type I ARCH and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's responsible placement agency, and others authorized by the resident to review it.</p> <p><u>FINDINGS</u> Resident #1 - No level of care prior to admission on 10/17/21. The level of care was completed on 10/22/21.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>PCG WILL HAVE A CHECKLIST REQUIREMENTS GIVEN TO THE DISCHARGING DOCTOR OR FACILITY. PCG WILL MAKE SURE THAT ALL ADMISSION REQUIREMENTS ARE GIVEN 3 DAYS PRIOR TO ADMISSION TO MAKE SURE EVERYTHING IS COMPLETE.</p>	<p style="text-align: right;">03/09/2022</p> <p style="text-align: right;">22 MAR 31 P12:23</p> <p style="text-align: right;">STATE OF HAWAII DPH-OPHA STATE LICENSES</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 order for the following medication recorded on the medication record:</p> <ol style="list-style-type: none"> 1. Clotrim/Beta Cre Diprop 2. Diabetic Tussin DM 3. Nystop Powder 4. Silvadene 5. Ondansetron 	<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>ON MARCH 9, 2022, RESIDENT'S APRN PROVIDER VISITED AND EXAMINED RESIDENT AND REVIEWED AND UPDATED HER MEDICATION ORDERS AND CARRIED OUT BY PCG.</p> <p>ON MARCH 10, 2022 RN CASE MANAGER CONDUCTED MONTHLY VISIT AND REVIEWED CURRENT MEDICATION ORDER FOR ACCURACY AND AVAILABILITY AT THE FACH. PCG AND RN CASE MANAGER REVIEWED MEDICATION LIST TOGETHER. CARE PLAN UPDATED ON 03/09/2022.</p>	<p>03/09/2022</p> <p style="text-align: right;">22 MAR 31 11:23</p> <p style="text-align: center;">STATE OF HAWAII DOH-080A PHIL LEESSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	<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 order for the following medication recorded on the medication record:</p> <ol style="list-style-type: none"> 1. Clotrim/Beta Cre Diprop 2. Diabetic Tussin DM 3. Nystop Powder 4. Silvadene 5. Ondansetron 	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>IF MEDICATION BROUGHT TO HOME HAS NO PCP ORDER, PCG WILL CALL PCP TO GET AN ORDER RIGHT AWAY. PCG WILL CHECK FOR PCP ORDER FOR EACH MEDICATION BEFORE RECORDING TO THE MAR.</p>	<p style="text-align: right;">06/23/22</p>

RECEIVED

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(1) 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>Documentation of primary care giver's assessment of resident upon admission;</p> <p>FINDINGS Resident #1 - No documentation of the primary care giver assessment of the resident upon admission.</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>	<p style="text-align: center;">'22 MAR 31 P12:24</p> <p style="text-align: center;">STATE OF HAWAII DOH-ORCA 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)(1) 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>Documentation of primary care giver's assessment of resident upon admission;</p> <p><u>FINDINGS</u> Resident #1 - No documentation of the primary care giver assessment of the resident upon admission.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>PCG WILL HAVE A CHECKLIST OF REQUIREMENTS UPON ADMISSION AND MAKE SURE EVERYTHING IS COMPLETED UPON ADMISSION AND KE AT THE RESIDENT'S CHART.</i></p>	<p style="text-align: right;"><i>03/08/2022</i></p> <p style="text-align: right;">*22 MAR 31 P12:24</p> <p style="text-align: right; font-size: small;">STATE OF HAWAII DOH-OHCA STATE 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)(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>FINDINGS Resident #1 - "Cleanse coccyx area pressure injury with wound cleaner, pat dry, apply duoderm patch and change every 3 days as needed" ordered 10/22/21; however, the treatment was not reflected on the plan of care/care plan.</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>RESIDENT'S COCCYX AREA PRESSURE INJURY WAS RESOLVED AS DOCUMENTED IN PROGRESS NOTES ON 11/20/21. PCG NOTIFIED PROVIDER AND PROVIDER ORDER TO KEEP CURRENT TREATMENT ORDER IF COCCYX AREA PRESSURE INJURY RE-OPEN.</p> <p>PCG CONTACTED RN CASE MANAGER TO UPDATE CARE PLAN WITH CURRENT PROVIDER'S ORDERS.</p> <p>RN CASE MANAGER UPDATED CARE PLAN ON 03/10/2022.</p>	<p style="text-align: right;">03/10/2022</p> <p style="text-align: right;">22 MAR 31 PM 2:24</p> <p style="text-align: right; font-size: small;">STATE OF HAWAII DON-ORICA STATE 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)(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><u>FINDINGS</u> Resident #1 - "Cleanse coccyx area pressure injury with wound cleaner, pat dry, apply duoderm patch and change every 3 days as needed" ordered 10/22/21; however, the treatment was not reflected on the plan of care/care plan.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>WHEN THERE IS A NEW PCP ORDER FOR MEDICATION & TREATMENT, I WILL NOTIFY THE CM RIGHT AWAY OF THE ORDER.</p> <p>I WILL ADD A NOTE TO THE RESIDENT'S BINDER FOR THE CM TO UPDATE THE CARE PLAN.</p> <p>I WILL DOCUMENT TELEPHONE CALL TO CM IN THE PROGRESS NOTE.</p>	<p style="text-align: center;">06/23/22</p>

RECEIVED

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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><u>FINDINGS</u> Resident #1 - "Cleanse moisture associated redness on groin areas, pat dry, sprinkle with Nystatin powder topical 2 times a day" ordered 10/22/21; however, the treatment was not reflected on the plan of care/care plan.</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;">PCG CONTACTED RN CASE MANAGER TO UPDATE THE PLAN OF CARE FOR THE RESIDENT AS HER MOISTURE ASSOCIATED REDNESS ON GROIN AREAS HAS TREATMENTS ORDERED BY HER PROVIDER THAT NEEDS TO BE INCLUDED IN HER CARE PLAN. RN CASE MANAGER UPDATED CARE PLAN ON 03/10/2022.</p>	<p>03/10/2022</p> <p style="text-align: right;">22 MAR 31 P12:24</p> <p style="text-align: right; font-size: small;">STATE OF HAWAII DON-ORCA STATE 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)(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>FINDINGS Resident #1 - "Cleanse moisture associated redness on groin areas, pat dry, sprinkle with Nystatin powder topical 2 times a day" ordered 10/22/21; however, the treatment was not reflected on the plan of care/care plan.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>WHEN THERE IS A NEW PCP ORDER FOR MEDICATION & TREATMENT, I WILL NOTIFY THE CM RIGHT AWAY OF THE CARE PLAN.</p> <p>I WILL DOCUMENT TELEPHONE CALL TO CM IN THE PROGRESS NOTES.</p>	<p style="text-align: center;">6/23/22</p>

RECEIVED

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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>FINDINGS Resident #1 - No nutrition plan of care/care plan. The resident needs to be fed by care givers, is unable to stand for weights and prefers ice cubes between spoonfuls at mealtime.</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>ON MARCH 10, 2022, RN CASE MANAGER CONDUCTED AN IN-SERVICE FOR PCG AND SCG'S REGARDING RESIDENT'S FEEDING NEEDS AS WELL AS SAFETY IN WEIGHING RESIDENT USING A HOYER LIFT. RN CASE MANAGER UPDATED CARE PLAN TO REFLECT RESIDENT'S CARE NEEDS, SERVICES AND/OR INTERVENTIONS ON 03/10/2022.</p>	<p>03/10/2022</p> <p style="text-align: right;">'22 MAR 31 PM 2:24</p> <p style="text-align: right; font-size: small;">STATE OF ILLINOIS DOH-ORCA STATE 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)(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>FINDINGS Resident #1 - No nutrition plan of care/care plan. The resident needs to be fed by care givers, is unable to stand for weights and prefers ice cubes between spoonfuls at mealtime.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I WILL RE-DO THE CARE PLAN IF THE CARE PLAN DOES NOT INCLUDE SERVICES WE PROVIDE SUCH AS FEEDING THE RESIDENT, OR IF THE RESIDENT CANNOT STAND FOR WEIGHTS, I WILL WORK w/ THE CARE MANAGER TO UPDATE THE CARE PLAN.</p>	<p>06/23/22</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)(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>FINDINGS Resident #1 - "Apply lap/seat belt while in wheelchair" ordered 10/22/21; however, the order was not reflected in the care plan.</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>PCC NOTIFIED RN CASE MANAGER REGARDING THE LAP/SEAT BELT ORDER THAT WAS NOT INDICATED ON HER CARE PLAN. RN CASE MANAGER UPDATED THE CARE PLAN TO REFLECT RESIDENT'S NEEDS TO APPLY LAP/SEAT BELT WHILE IN WHEELCHAIR AS ORDERED BY PROVIDER UNDER AT RISK FOR FALL CARE PLAN ON 03/10/2022.</p>	<p>03/10/2022</p> <p style="text-align: right;">22 MAR 31 PM 2:24</p> <p style="text-align: right; font-size: small;">STATE OF HAWAII DOH-ORCA STATE 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)(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>FINDINGS Resident #1 - "Apply lap/seat belt while in wheelchair" ordered 10/22/21; however, the order was not reflected in the care plan.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>WHEN THERE IS A NEW ORDER FROM PCP FOR "APPLY LAP/SEAT BELT WHILE IN WHEEL CHAIR. I WILL NOTIFY THE CM RIGHT AWAY OF THE ORDER.</p> <p>I WILL ADD A NOTE TO THE RESIDENT'S BINDER FOR THE CM TO UPDATE THE CARE PLAN.</p> <p>I WILL DOCUMENT TELEPHONE CALL TO CM IN MY PROGRESS NOTES.</p>	<p style="text-align: right;">06/23/22</p>

RECEIVED
 JUN 23 2022

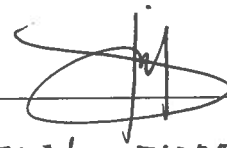
	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(4) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration 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>FINDINGS Resident #1 - The "Potential for Aspiration due to Dementia" plan of care intervention noted: "provide food in small amounts cut food in small pieces or puree with thickened liquids;" however, there is no physician order for modified consistency solids and liquids.</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>ON MARCH 9, 2022, APRN PROVIDER RE-EVALUATED RESIDENT'S DIET ORDERS AND CONSISTENCY. PCC NOTIFIED RN CASE MANAGER.</p> <p>RN CASE MANAGER CONDUCTED IN-SERVICE ON DIET CONSISTENCY AND SAFETY PRECAUTION FOR ASPIRATION TO PCC AND ALL SCGS. RN CASE MANAGER UPDATED RESIDENT'S CARE PLAN ON 03/10/2022.</p>	<p>03/09/2022</p> <p style="text-align: right;">22 MAR 31 P12:24</p> <p style="text-align: right; font-size: small;">STATE OF ILLINOIS DEPARTMENT OF HEALTH STATE 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)(4)</p> <p>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><u>FINDINGS</u></p> <p>Resident #1 - The "Potential for Aspiration due to Dementia" plan of care intervention noted: "provide food in small amounts cut food in small pieces or puree with thickened liquids;" however, there is no physician order for modified consistency solids and liquids.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I WILL READ CARE PLAN IF THE CARE PLAN INTERVENTIONS REQUIRE A PHYSICIAN ORDER. FOR EXAMPLE MODIFIED CONSISTENCY SOLIDS & LIQUIDS.</p> <p>I WILL WORK w/ THE CM TO GET THE PHYSICIAN ORDER.</p>	<p>06/23/22</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)(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>FINDINGS Resident #1 - "The Hypertension due to Disease Process" intervention noted: "check BP daily before giving BP meds;" however, no physician order for BP medication.</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>PCG REVIEWED CARE PLAN AND CONTACTED RN CASE MANAGER ON THE ERROR THAT WAS WRITTEN ON HER CARE PLAN REGARDING CHECKING HER BP BEFORE GIVING BP MEDICATION WHEN RESIDENT'S PROVIDER DON'T HAVE ANY BP MEDICATION ORDER.</p> <p>RN CASE MANAGER UPDATED CARE PLAN IMMEDIATELY UPON PCG REPORTING THE ERROR.</p>	<p style="text-align: right;">03/10/2022</p> <p style="text-align: right;">22 MAR 31 PM 2:24</p> <p style="text-align: right;">STATE OF HAWAII DEPARTMENT OF HEALTH STATE 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)(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><u>FINDINGS</u> Resident #1 - "The Hypertension due to Disease Process" intervention noted: "check BP daily before giving BP meds;" however, no physician order for BP medication.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>PCG SHOULD CAREFULLY REVIEW CARE PLAN AS IT IS THE GUIDE ON RESIDENT'S PLAN OF CARE. ANYTHING INCORRECT WRITTEN AT THE CARE PLAN SHOULD BE NOTED AND REPORTED TO THE RN CASE MANAGER IMMEDIATELY TO ACQUIRE AN UPDATED AND CORRECT PLAN OF CARE.</p>	<p>03/10/2022</p> <p style="text-align: right;">22 MAR 31 PM 2:24</p> <p style="text-align: right; font-size: small;">STATE OF HAWAII DOH-DHCA STATE LICENSING</p>

Licensee's/Administrator's Signature: _____



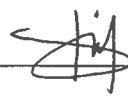
Print Name: _____

JOAN FLORES

Date: _____

03/31/2022

Licensee's/Administrator's Signature: _____



Print Name: _____

JOAN FLORES

Date: _____

06/23/22

STATE OF HAWAII
DOH-DHCA
STATE LICENSING

'22 MAR 31 PM 12:24