

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name:</b> Parubrub, Tina (ARCH)	<b>CHAPTER 100.1</b>
<b>Address:</b> 94-1108 Hina Street, Waipahu, Hawaii 96797	<b>Inspection Date:</b> June 15, 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.**

22 AUG 29 AM 12:21  
STATE LICENSING SECTION  
OFFICE OF HEALTH CARE ASSURANCE

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-8 <u>Primary care giver qualifications.</u> (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall:</p> <p>Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current;</p> <p><b><u>FINDINGS</u></b> Primary Caregiver (PCG) – No documented evidence of six hours of training sessions completed between 6/2021-6/2022</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 HAWAII DEPARTMENT OF STATE LICENSING</p>	<p>7/29/22</p> <p>22 AUG -1 P 3:39</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-8 <u>Primary care giver qualifications.</u> (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall:</p> <p>Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current;</p> <p><b><u>FINDINGS</u></b> Primary Caregiver (PCG) – No documented evidence of six hours of training sessions completed between 6/2021-6/2022</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 utilize a check list to include complete six hours of training inservices. I will review this check list every 3 mos. to ensure that is being done and documented and kept current in my record.</i></p>	<p>7/29/22</p> <p>22 AUG -1 P3:39</p> <p>STATE OF HAWAII DOR-0104 STAFF LOCKING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.</p> <p><b><u>FINDINGS</u></b> Toxic chemicals (e.g., bleach and cleaning agents) stored in unsecured cabinet next to dining table.</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> <p style="text-align: center;"><i>I locked the cabinet that contains chemical and pesticides.</i></p>	<p><i>8/29/22</i></p> <p style="text-align: right;">22 AUG 29 AM 10:21 STATE OF KANSAS DEPARTMENT OF HEALTH OFFICE OF INSPECTION</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 Food sanitation. (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.</p> <p><b><u>FINDINGS</u></b> Toxic chemicals (e.g., bleach and cleaning agents) stored in unsecured cabinet next to dining table.</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 <del>post</del><sup>post</sup> a reminder sign to locked the cabinet door that contains cleaning chemicals and pesticides. I will post it on the cabinet door.</i></p>	<p>8/29/22</p> <p>22 AUG 29 AM 12:21</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (a)  All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms.</p> <p><b><u>FINDINGS</u></b>  Resident #1 – Medication administration record states, “Multivitamins tab 1 tab P.O. daily” as being administered; however, no physician’s order available for multivitamin</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> <p style="text-align: center;"><i>Order for Multi-Vitamin was obtain from residents doctor.</i></p>	<p><i>8/29/22</i></p> <p style="text-align: right;">22 AUG 29 10:21</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (a)  All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms.</p> <p><b><u>FINDINGS</u></b>  Resident #1 – Physician's order dated 4/21/22 states, "Risperidone 1mg 1 tab PRN"; however, no PRN indication provided. Medication order incomplete.</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> <p><i>I spoke to Doctor on 7/29/22 and medication discontinued.</i></p>	<p><i>8/29/22</i></p> <p>22 AUG 29 AM 11:21</p>



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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms.</p> <p><b><u>FINDINGS</u></b> Resident #1 – Physician's order dated 4/21/22 states, "Risperidone 1mg 1 tab PRN"; however, no PRN indication provided. Medication order incomplete.</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 to remind all P.R.N. medications order that the instructions is included while at doctor office to ensure I do not leave without complete orders. I will post reminder note on residents binder.</i></p>	<p><i>8/29/22</i></p> <p>22 AUG 29 AM 0:21</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p><b><u>FINDINGS</u></b> Resident #1 – Response to daily and as needed medication not provided in monthly progress notes</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 HAWAII DEPARTMENT OF HEALTH STATE LICENSING</p>	<p>7/29/22</p> <p>22 AUG -1 P 3:40</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 Records and reports. (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p><b>FINDINGS</b> Resident #1 – Monthly progress note for 5/2022, written on 5/31/22, states “Any changes to condition: N”; however, resident experienced a change in condition which led to an ER visit on 5/24/22. Monthly progress note information did not accurately reflect client’s condition.</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 HAWAII DEPARTMENT OF HEALTH STATE LICENSING</p>	<p>7/29/22</p> <p>22 AUG -1 P 3:40</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>11-100.1-17 <u>Records and reports.</u> (c)  Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary.</p> <p><b><u>FINDINGS</u></b>  Resident #1 – No documented evidence an incident report was made for change in resident's condition resulting in ER visit on 5/24/22.</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 HAWAII  DEPARTMENT OF HEALTH  STATE LICENSING</p>	<p>7/29/22</p> <p>22 AUG -1 P 3:40</p>



	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-20 <u>Resident health care standards.</u> (a) The primary and substitute care giver shall provide health care within the realm of the primary or substitute care giver's capabilities for the resident as prescribed by a physician or APRN.</p> <p><b><u>FINDINGS</u></b> Resident #1 – Physician's order dated 1/28/22 and 4/21/22 state, "will ask caregiver to take blood pressure in am at least every other morning"; however, no documented evidence blood pressure readings were 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>7/29/22</p> <p>22 AUG -1 P3:40</p> <p>STATE OF MARYLAND DOH-2452 STAT-LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-20 <u>Resident health care standards.</u> (a) The primary and substitute care giver shall provide health care within the realm of the primary or substitute care giver's capabilities for the resident as prescribed by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Physician's order dated 1/28/22 and 4/21/22 state, "will ask caregiver to take blood pressure in am at least every other morning"; however, no documented evidence blood pressure readings were 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 post all treatments orders on the front cover of the residents binder as a reminder to carry out the order. I post a note on carehome binder to post all treatment orders on residents binder cover.</i></p>	<p><i>8/29/22</i></p> <p>22 AUG 29 REC-21</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-20 <u>Resident health care standards.</u> (c) The primary and substitute care giver shall be able to recognize, record, and report to the resident's physician or APRN significant changes in the resident's health status including, but not limited to, convulsions, fever, sudden weakness, persistent or recurring headaches, voice changes, coughing, shortness of breath, changes in behavior, swelling limbs, abnormal bleeding, or persistent or recurring pain.</p> <p><b>FINDINGS</b> Resident #1 – Resident experienced a 20lb weight loss between 6/2021 (614lbs) and 6/2022 (144lbs); however, no documented evidence resident's physician was notified of weight loss trend at any point in time.</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> <p><i>I took resident #1 3 med-follow-up and update all her meds. Diet order is regular. Cont all current meds. no new med given. P.C.P and discuss w/ty resident #1 loosing weight. P.C.P. refer her to take blood test. Blood test taken on 7/16/22. Call P.C.P. ask the result of her blood test and he said everything is normal. Cont to maintain her good health and <sup>give</sup> her healthy food.</i></p>	<p><i>7/29/22</i></p> <p><i>22 AUG -1 P3:39</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-20 <u>Resident health care standards.</u> (c)            The primary and substitute care giver shall be able to recognize, record, and report to the resident's physician or APRN significant changes in the resident's health status including, but not limited to, convulsions, fever, sudden weakness, persistent or recurring headaches, voice changes, coughing, shortness of breath, changes in behavior, swelling limbs, abnormal bleeding, or persistent or recurring pain.</p> <p><b><u>FINDINGS</u></b>            Resident #1 – Resident experienced a 20lb weight loss between 6/2021 (614lbs) and 6/2022 (144lbs); however, no documented evidence resident's physician was notified of weight loss trend at any point in time.</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 post a reminder note to notify residents' doctor, when he or she experiences more than five pounds of weight loss in 1 month.</i></p>	<p><i>8/29/22</i></p> <p>22 AUG 29 MON 21</p> <p>STATE OF CONNECTICUT            DEPARTMENT OF            SOCIAL SERVICES            STATE LIAISON</p>

Licensee's/Administrator's Signature: Tina Parubrub

Print Name: TINA Parubrub

Date: 7/29/22

STATE OF HAWAII  
DOH-CHCA  
STATE LICENSING

22 AUG -1 P 3:40

Licensee's/Administrator's Signature: Tina Parubra b

Print Name: TINA Parubra b

Date: 8/29/22

STATE OF HAWAII  
DEPARTMENT OF  
STATE LICENSES

22 AUG 29 410:21