Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: E & R	**CHAPTER 100.1**
Address: **3034 Kalihi Street, Honolulu, Hawaii 96819**	**Inspection Date: February 28, 2023 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
☒	§11-100.1-3 Licensing. (b)(1)(I) Application. 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: 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; **FINDINGS** Primary caregiver (PCG), substitute caregiver (SCG) #1, and SCG #2 – No documentation of background check clearance (Fieldprint).	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** 1 PCG has been scheduled for Tomorrow May 24, 2023 @ 1:00 p.m to do finger print with Field print. SCG # 1 was on vacation shedule finger print when she come back. SCG # 2 Completed 7-21-22	05-23-23

'23 MAY 23 AM 10:55

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☒	§11-100.1-3 Licensing. (b)(1)(I) Application. 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: 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; **FINDINGS** Primary caregiver (PCG), substitute caregiver (SCG) #1, and SCG #2 – No documentation of background check clearance (Fieldprint).	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I shall require all PCGs, SCGs and family household members to submit documented evidence of background check clearance (fieldprint) before allowing to work/live and have access to the ARCH/Expanded ARCH areas to ensure they have no prior felony or abuse conviction in the Court of law. All background check clearances shall be kept on file in a manual folder. I shall review these documents every 6 months/yearly to ensure compliance with requirements.	3/22/23

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** SCG #2 – No documentation of physical examination. *Please submit a copy with your plan of correction (POC)* STATE OF HAWAII DOH-CCBA STATE LICENSING '23 MAY -5 P2:13	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** Yes **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I talked to SCG #2 after the inspection about her current P.E. She said she has a current P.E. SCG #2 faxed her annual PE done on 7/13/2022 to me. See attached.	4/25/22

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** SCG #2 – No documentation of physical examination. *Please submit a copy with your plan of correction (POC)*	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I shall request for a copy of SCGs P.E. before allowed to work with residents to ensure that she is free of infectious disease. All P.E.s of care givers + household members shall be updated annually. If there is no documentation of physical examination, SCGs shall not be allowed to provide care or services to residents in Type I ARCH. I shall file all P.E.s of care givers + household members in Manual folder. I shall review all caregivers P.E. q 6 mo/annually to ensure compliance with requirements.	3/22/23

23 APR -4 P2:12

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; **FINDINGS** SCG #2 – No documentation of first aid certification. *Please submit a copy with your plan of correction (POC)*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** Yes **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I talked to SCG #2 about her First Aid Certification after the inspection. She said she has a current First Aid Certificatin. She faxed her First Aid Certification to me completed on 7/2/2022. See attached.	4/25/22

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; **FINDINGS** SCG #2 – No documentation of first aid certification. *Please submit a copy with your plan of correction (POC)*	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I shall request for a copy of SCGs first aid certification before allowed to work with residents to ensure current certification. If there is no evidence of current certification, SCGs shall not be allowed to provide care or services to the residents. I shall file all first aid certifications of care givers in manual folder. I shall review all caregivers first aid certifications q (6 mo/annually to ensure compliance with requirements.	3/22/2023

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall: Be currently certified in cardiopulmonary resuscitation; **FINDINGS** SCG #2 – No documentation of cardiopulmonary resuscitation (CPR) certification.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** Yes **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I talked to SCG #2 after the inspection about her current CPR Certification. She said she has a current CPR Certification. She faxed her current CPR Certification completed on 7/2/2022 to me. See attached.	4/25/22

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall: Be currently certified in cardiopulmonary resuscitation; **FINDINGS** SCG #2 – No documentation of cardiopulmonary resuscitation (CPR) certification.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I shall request for a copy of SCGs CPR certification before allowed to work with residents to ensure current certification. If there is no evidence of current certification, SCGs shall not be allowed to provide care or services to the residents. I shall file all CPR certifications of Caregivers in Manual folder. I shall review all Caregivers CPR certifications q 6mo/annually to ensure compliance with requirements	3/22/23

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (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. **FINDINGS** Resident #1 – Physician order dated 2/14/23 states Jevity 240 ml via G-tube QID. However, formula was not available for the resident. Per PCG, the formula was out of stock, and the resident is currently using Fibersource HN 1.2. cal 250 ml. No order clarification to administer the new formula. *Obtain order clarification and submit a copy with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** yes **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I contacted Dr. Melissa McKinney, DO and obtained a telephone order to substitute the current formula Resident #1 was using: Jevity 240 ml via G-tube QID (not available) to the new formula: Fibersource HN 1.2 Cal 250 ml via G-tube QID. See attached.	3/23/23

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (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. **FINDINGS** Resident #1 – Per PCG, Fibersource HN 1.2 cal 250 ml was started on or about February 2023 but not recorded on the February medication administration record (MAR).	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; **FINDINGS** Resident #1 – Physician statement dated 2/13/23 shows TB skin test was not administered due to refusal; however, TB clearance was issued for a negative skin test. TB clearance is not acceptable.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** yes **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** After I received my UPOC notice, I contacted the TB Branch as recommended for proper endorsement. I explained that my resident refused TB Clearance test from the MD. Appointment was given on 4/28/2023. I took resident #1 for TB clearance at TB Branch on 4/28/2023. Resident #1 was given Certificate of TB clearance. See attached.	4/28/23

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: 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; **FINDINGS** No progress notes for the month of January for residents #1 and #2.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** STATE OF HAWAII DOH-CHSD STATE LICENSING '23 APR -4 P2:13	

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Licensee's/Administrator's Signature: Remedios Bhon

Print Name: REMEDIOS BHON

Date: 04-03-2023

Licensee's/Administrator's Signature: Remedios Brion

Print Name: Remedios Brion

Date: 05-04-2023

Licensee's/Administrator's Signature: Remedios Brion

Print Name: Remedios Brion

Date: 5-23-23