Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Abad, Edna (ARCH)	CHAPTER 100.1
Address: 98-312 Kaluamoi Drive, Pearl City, Hawaii 96782	Inspection Date: April 11, 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 Care Giver, Substitute Care Giver (SCG) #1, SCG #2 – No current documented evidence stating aforementioned care givers have no prior felony or abuse convictions in a court of law. Please submit a copy of field print results as evidence of completion.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** PCG, SCG #1, SCG #2, HAS OBTAINED FIELD PRINT RESULTS. COPIES HAS SUBMITTED ALREADY.	5/15/23

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	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 Care Giver, Substitute Care Giver (SCG) #1, SCG #2 – No current documented evidence stating aforementioned care givers have no prior felony or abuse convictions in a court of law. Please submit a copy of field print results as evidence of completion.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** MAKE A CHECK LIST TO REMIND US TO DO FIELD PRINT ON TIME WHEN IS DUE FOR 2 (TWO) YEARS AND THEN EVERY OTHER YEAR AFTER. SEE ATTACHED.	5/15/23

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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 Care Giver #2 – No documented evidence of an initial two-step Tuberculosis (TB) skin test. Please submit a copy of TB assessment as evidence of completion.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** SUBSTITUTE CARE GIVER #2 SEND TO HIS PRIMARY CARE PHYSICIAN TO HAVE THE TWO-STEP TUBERCULOSIS (TB) SKIN TEST CLEARANCE. SEE ATTACHED.	5/1/23

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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 Care Giver #2 – No documented evidence of an initial two-step Tuberculosis (TB) skin test. Please submit a copy of TB assessment as evidence of completion.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** MAKE A CHECK LIST TO REMIND US THAT WE NEED TO HAVE A CURRENT TUBERCULOSIS (TB) CLEARANCE ON DUE DATE. SEE ATTACHED.	5/1/23

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. **FINDINGS** Substitute Care Giver #2 – No documented evidence that SCG received training to make prescribed medications available for residents.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** PROVIDED TRAINING TO THE SUBSTITUTE CARE GIVER #2 INORDER TO BE ABLE TO MAKE PRESCRIBED MEDICATIONS FOR THE RESIDENTS.	4/13/23

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. **FINDINGS** Substitute Care Giver #2 – No documented evidence that SCG received training to make prescribed medications available for residents.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** IN THE FUTURE, TO PREVENT THIS FROM HAPPENING AGAIN, PCG HAS POSTED A CHECKLIST TO KEPT IN THE CARE HOME BINDER AS A REMINDER. ALL SUBSTITUTE CARE GIVERS HAVE BEEN RECEIVED TRAINING TO MAKE PRESCRIBED MEDICATIONS AVAILABLE FOR RESIDENTS. STATE OF HAWAII DOH-OHCA STATE LICENSING	4/13/23 '23 JUL -3 P1:06

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-16 Personal care services. (h) A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed. **FINDINGS** Resident #1 –Schedule of Activities dated 4/20/20 included attending program daily from Monday to Friday from 10:00 am to 2:00 pm. PCG reports that resident has not attended program since February of 2021 due to Covid-19. No documented evidence of an updated schedule of activities.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** MADE A CURRENT SCHEDULE OF ACTIVITIES EVERYTIME THERE IS A NEW CHANGES OF SCHEDULE OF ACTIVITIES.	4/14/23

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-16 Personal care services. (h) A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed. **FINDINGS** Resident #1 –Schedule of Activities dated 4/20/20 included attending program daily from Monday to Friday from 10:00 am to 2:00 pm. PCG reports that resident has not attended program since February of 2021 due to Covid-19. No documented evidence of an updated schedule of activities.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** IN THE FUTURE, TO PREVENT THIS FROM HAPPENING AGAIN, PCG HAS POSTED A CHECKLIST TO KEPT IN THE CARE HOME BINDER AS A REMINDER. PROVIDE AND POSTED AN UPDATED SCHEDULE OF ACTIVITIES TO ALL RESIDENTS. STATE OF HAWAII DOH-OHCA STATE LICENSING	4/14/23 '23 JUL -3 P1 :06

Licensee's/Administrator's Signature: Edna S. Abad

Print Name: EDNA S. ABAD

Date: 5/16/2023

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Licensee's/Administrator's Signature: Edna S. Abad

Print Name: EDNA S. ABAD

Date: 6/26/23

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