Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: **Castanaga, Imelda (ARCH/Expanded ARCH)**	**CHAPTER 100.1**
Address: **94-972 Lumimoe Street, Waipahu, Hawaii 96797**	**Inspection Date: August 17, 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) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	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 Caregiver (SCG) #1 – Primary caregiver (PCG) training unavailable for review. Submit a copy with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Substitute Caregiver Training ~~Hours~~ completed and kept in ACH master binder Enclosed a copy	8/20/23

	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 Caregiver (SCG) #1 – Primary caregiver (PCG) training 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?** I will make a reminded on my calendar that medication training done every year.	8/20/23

	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 – The following medication orders dated 6/1/23, and subsequent medication bottle labels are incomplete (missing PRN indication): • "Acetaminophen 500mg 2 tab q 4hrs as needed" • "Fluticasone nasal spray (Flonase) 50mcg 1 spray to both nostrils 2x a day as needed" Submit revised medication orders with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** MD appointment checklist created and placed in front of residents chart. All orders shall be reviewed at time of appointment for any clarifications and medication PRN indication ordered. Enclosed a copy of revised medication order.	9/1/23

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☒	§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 – The following medication orders dated 6/1/23, and subsequent medication bottle labels are incomplete (missing PRN indication): • "Acetaminophen 500mg 2 tab q 4hrs as needed" • "Fluticasone nasal spray (Flonase) 50mcg 1 spray to both nostrils 2x a day as needed" Submit revised medication orders 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?** I will have MD approved check list; Review chart Prepare notes Review all orders > PRN indicated > clarifications needed Place in front of resident chart. Enclose a copy of current medications labeled	11/1/23

	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 – Annual tuberculosis clearance unavailable for review. Submit a copy with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Annual tuberculosis clearance done. Enclosed a copy	9/1/23

	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 – Annual 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?** Checklist created for annual chart review and placed in front of residents binder. Reminder written on master calendar for annual TB Testing.	9/1/23

Licensee's/Administrator's Signature: Imelda B. Castanaga

Print Name: IMELDA B. CASTANAGA

Date: 10/31/23