

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Nebreja, Raymunda	CHAPTER 100.1
Address: 94-023 Poailani Circle, Waipahu, Hawaii 96797	Inspection Date: July 22, 2024 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 PER HAR 11-100.1-3(e)(2). IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

FAILURE TO CORRECT CITED DEFICIENCIES AS PER THE PLAN OF CORRECTION COULD RESULT IN REFUSAL TO RENEW YOUR LICENSE PER HAR 11-100.1-3(e)(3).

	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><u>FINDINGS</u> Resident #1 – Observed “Neosporin” antibiotic ointment on resident dresser, unlabeled and unsecured.</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><i>I make sure that I restore it proper place. I throw it away.</i></p>	<p><i>7/22/24</i> <i>Phibey</i></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><u>FINDINGS</u> Resident #1 – Observed “Neosporin” antibiotic ointment on resident dresser, unlabeled and unsecured.</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>I make sure I will put on keep it in proper place where to be keep & make sure there in label. Me & substitute care giver med must be recorded monthly</i></p>	<p>24 (Date) P1 218</p> <p>STATE OF</p> <p>10/25/24 P.H.</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.</p> <p>FINDINGS Resident #1 – Observed “Neosporin” antibiotic ointment on resident dresser, unlabeled and unsecured.</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>This is empty I make sure I will throw it away & if it's not empty I will keep it + cover it and put it in the medicine kit.</i></p>	<p>24 OCT 30 10:28</p> <p>STATE</p> <p><i>10/25/14</i> <i>R.H.</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (1) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.</p> <p><u>FINDINGS</u> Resident #1 – Observed “Neosporin” antibiotic ointment on resident dresser, unlabeled and unsecured.</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>I make sure that after I apply I make sure I will return or keep it in the proper place where I put in the med. kit.</i></p> <p><i>My combi tubette given & I make sure restore ^{meds} in proper place daily</i></p>	<p style="text-align: right;">'24 OCT 31 P1 2028</p> <p style="text-align: right;">STATE...</p> <p style="text-align: right;"><i>10/25/24</i></p> <p style="text-align: right;"><i>Platby</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(7) During residence, records shall include:</p> <p>Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency;</p> <p>FINDINGS Resident #1, Resident #2, Resident #3 – No documented evidence that a monthly weight was taken from August 2023 to present.</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><i>I do take monthly weight but I did not copy from my list scratch to the other form. I make sure I send record direct to the the form.</i></p>	<p>24 OCT 30 11 48</p> <p>STATE OF CONNECTICUT</p> <p>10/25/24 <i>[Signature]</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(7) During residence, records shall include:</p> <p>Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency;</p> <p>FINDINGS Resident #1, Resident #2, Resident #3 – No documented evidence that a monthly weight was taken from August 2023 to present.</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>I make sure I will take every month & I will directly record it to the weight form. I make sure I will put a post reminder on the calendar</i></p>	<p>24 OCT 30 P 1:48</p> <p>STATE STAFF</p> <p><i>10/25/24</i> <i>[Signature]</i></p>

Licensee's/Administrator's Signature: Raymunda C. Nebreja

Print Name: RAYMUNDA C. Nebreja

Date: October 25, 2024

Licensee's/Administrator's Signature: Raymunda C. Nebreja

Print Name: RAYMUNDA C. Nebreja

Date: October 25, 2024