Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Bagain Cadiz Care Home	CHAPTER 100.1
Address: 94-1381 Hiaai Place, Waipahu, Hawaii 96797	Inspection Date: May 11, 2015 Annual

	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 [redacted]	CHO sat with (SCG) for skills review for each resident's medication lists as scheduled and PRN. Upon this evaluation and from now on, training will be documented in the progress notes.	06/03/15
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.		

	FINDINGS [redacted]	CHO will perform routine medication reconciliation to ensure availability of all medications as prescribed. Physician parameter instructions will be listed in the medication records. CHO will be using her own medication administration record given by OHCA to avoid any discrepancies made by the pharmacy. CHO will make sure the medication is made available as soon as it is prescribed. For these medications with a delay, necessary documentation will be noted as to reason for delay (pharmacy closed/not delivered, other circumstances that are not under the control of the CHO) –delays will be communicated to physician in a timely manner and documented in chart.	06/03/15
☒	§11-100.1-17 Records and reports. (a)(3) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Documentation of date of referral and admission, referral agency with address and telephone number, place or source from which admitted, physician, APRN, dentist, ophthalmologist, optometrist, psychiatrist, and all other medical or social service professionals who are currently treating the resident, next of kin, legal guardian, surrogate or other legally responsible agency; FINDINGS [redacted] resident emergency information sheet was incomplete and did not contain the resident's current medication list and diagnoses.	Upon admission, readmission, or transfer of a resident, CHO will update and complete the resident's emergency information, including medication lists and diagnosis.	06/03/15

☒	§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** [redacted]	CHO will document reason/indication for medication including diagnosis and monitor symptoms, and response to medications in the progress notes. CHO will update notes accordingly.	06/03/15

Licensee/Administrator's Signature: [signature]

Print Name: Vicky Cadiz Bagain EARCH

Date: 06-04-15

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	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** No documentation that the primary care giver (PCG) provided substitute care givers (SCG) [redacted] training to make prescribed medications available.	11-100-1-9(e)(4) I will make sure that all my (SCG) [redacted] have their inservice training documented and maintained and kept in the care home folder. And in January I will make sure that they all have completed 12 hrs. inservice training kept in file	6-30-15
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.	three month before my annual inspection which due on every 2nd Thursday of April.	

	FINDINGS [redacted]	2) 11-100-15(E): [redacted] From now on I will make sure that parameter administration should be documented, and also inform the Pharmacy that they should also put that in the medication and recorded in the bottle that is prescribed by the physician. So that all routine medication will be recorded and followed in the residents mar.	06-30-15
☒	§11-100.1-17 Records and reports. (a)(3) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Documentation of date of referral and admission, referral agency with address and telephone number, place or source from which admitted, physician, APRN, dentist, ophthalmologist, optometrist, psychiatrist, and all other medical or social service professionals who are currently treating the resident, next of kin, legal guardian, surrogate or other legally responsible agency; **FINDINGS** [redacted]esident emergency information sheet was incomplete and did not contain the resident's current medication list and diagnoses.	3) 11-100.1-17(A)(3) From now on, I will make sure to update current residents emergency information including medication list, and diagnosis and kept at all times in the residents binder. Also if the physicians has any changes in the residents medication, I will make sure to change the emergency information sheet in order to update current medication. So that if residents goes to ER all medications is updated and recorded including there flu shot and TB skin test.	06-30-15

☒	§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** [redacted]		

Licensee/Administrator's Signature: Vicky C. Bagain Earch

Print Name: VICKY CHOIZ BAGAIN EARCH

Date: 07-02-15