Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Captain Cook Care Home	**CHAPTER 100.1**
Address: **81-1993 Haku Nui Road, Captain Cook, Hawaii 96704**	**Inspection Date: March 6, 2015 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§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]		

	Rules (Criteria)	Plan of Correction	Completion Date
	[redacted]		
☒	§11-100.1-15 Medications. (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year. [redacted]		
☒	§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 [redacted]		

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-17 Records and reports. (a)(6) 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: Physician or APRN signed orders for diet, medications, and treatments; **FINDINGS** [redacted]		
☒	§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]		
☒	§11-100.1-17 Records and reports. (g) All information contained in the resident's record shall be		

	Rules (Criteria)	Plan of Correction	Completion Date
	confidential. Written consent of the resident, or resident's guardian or surrogate, shall be required for the release of information to persons not otherwise authorized to receive it. Records shall be secured against loss, destruction, defacement, tampering, or use by unauthorized persons. There shall be written policies governing access to, duplication of, and release of any information from the resident's record. Records shall be readily accessible and available to authorized department personnel for the purpose of determining compliance with the provisions of this chapter. **FINDINGS** [redacted]		
☒	§11-100.1-23 Physical environment. (g)(3)(B) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: There shall be a clear and unobstructed access to a safe area of refuge; **FINDINGS** A gate was installed on the lanai to the front exit. The heavy wooden gate had to be lifted and pushed with effort to open.		

See attached pages for plan of correction.

Licensee/Administrator's Signature: _____

Print Name: _____

Date: _____

11-100.1-15 (e)

To prevent this from happening again, I will follow these steps:

1. Upon admission of the resident, I will read the Physician/APRN order and match up the order with each medication, supplement etc. brought to the care home.
2. If the physician order record is not accompanied by the resident, I will not admit the resident until there is a Physician/APRN order record that matches up with the medication, supplement etc.
3. Whenever a new Physician/APRN order of medication to be given to a resident or discontinue a medicine, I will accurately write the correct order on the Medication Flow Sheet of the resident, name of medication, frequency, time, date medication was ordered by the Physician/APRN.
4. I will initial every day or as directed by the Physician/APRN when I give the medication to a resident.
5. I will review Physician/APRN order and match up the Physician/APRN order with the label on the medication bottle.
6. I will show the substitute care giver how to administer medication/supplement and initial every day on the Medication Flow Sheet if he/she is administering medication or supplement to a resident as ordered by the Physician/APRN.

11-100.1.-15 Medications (g):

In the future, I will do the following:

1. After Resident [redacted] first visit from the doctor, four months from that day or as ordered by the doctor, I will document on the calendar when [redacted] next four month or as ordered by the doctor's appointment is due.
2. When Resident [redacted] has a checkup (every four months or as ordered by the Physician), I will bring a copy of the existing Physician Order record each time Resident [redacted] visits [redacted] doctor/APRN.
3. I will have the doctor review the existing Physician Order record and have the doctor update [redacted] medication to either discontinue or add new medication.
4. Upon return home, I will document and update new Physician Order on the Medication Record.

[redacted]

11-100-15 Medications (m):

[redacted]

I will do the following:

1. After each medication flow sheet is filled out and completed, I will file the medication flow sheet in the appropriate slot in Resident [redacted] chart.
2. Every time a substitute care giver administers medication or supplement to Res [redacted] I will make sure that he/she initial on the date that meds have been passed.

[redacted]

11-100.1-17 (a) (6)

To prevent this from happening again, I will do the following:

1. Three days prior to admission, give the Physician/APRN form to the resident's family and have the resident's doctor itemize all medication and diet orders as necessary before admission to the care home.
2. If not filled out, I will not admit the resident to the care home.

[redacted]

11-100.1-17 Records & Reports (b) (3):

[redacted]

In the future, progress notes will reflect detailed information on all behaviors and observations of injuries immediately when any incident occurs similarly to the incident report.

[redacted]

11-100.-23 (g) (3) (B)

To prevent this from happening again,

1. Whenever, I install a gate, door way, or change anything to do with the physical environment of the care home, I will refer to Chapter 11 100.1 and read 11-100.1-23 – specifically 100.-23 (g) (3) (B) for compliance.
2. I will comply with the rules and install a gate that opens freely without obstruction.
3. I fixed the gate so that the gate can open freely.

[redacted]

11-100.1-17 Records & Reports (g):

Will call on primary physician to have all medications ordered by other doctors (specialists) to write all updated medications/supplements on Physician/APRN Record. Will no longer cut and paste name of medication on the medication flow sheet. Will re-write medications as ordered by the primary physician and specialist with correct frequency, time and date

In the future, all medications/supplements will be written or type in with appropriate medications/supplements with correct frequency, time and date and not cut out or glued on the medication record.

[redacted]