

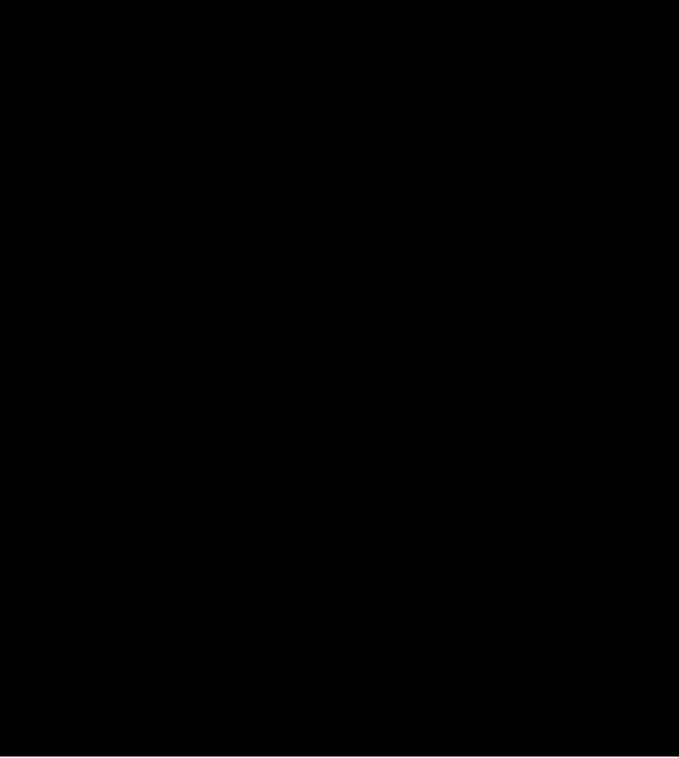
Office of Health Care Assurance

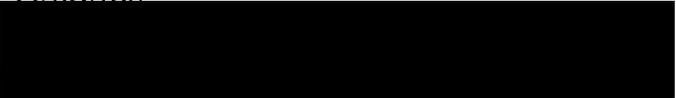
State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Hale Lehua CareHome	CHAPTER 100.1
Address: 984 Ala Lehua Street, Honolulu, Hawaii 96818	Inspection Date: October 2, 2015 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><u>FINDINGS</u> SCG [REDACTED] - No training by the primary care giver to make prescribed medication available to residents. Submit copy of training with the plan of correction (POC).</p>		
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.</p>		

	<p>FINDINGS</p> 		
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p>FINDINGS</p> 		
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (h)</p>		

	<p>All telephone and verbal orders for medication shall be recorded immediately on the physician's order sheet and written confirmation shall be obtained at the next physicians visit and not later than four months from the date of the verbal order for the medication.</p> <p>FINDINGS </p>		
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p>FINDINGS </p>		
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>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;</p> <p>FINDINGS </p>		

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Licensee/Administrator's Signature: _____

Print Name: _____

Date: _____

Office of Health Care Assurance

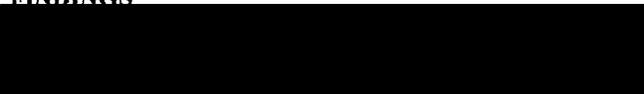
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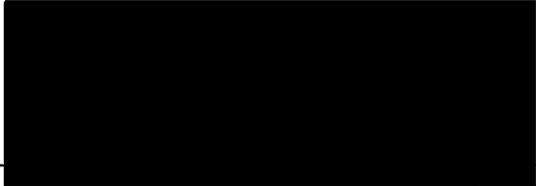
	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p>FINDINGS SCG [REDACTED] - No training by the primary care giver to make prescribed medication available to residents. Submit copy of training with the plan of correction (POC).</p>	<p>The Primary Caregiver (PCG) is responsible for the proper training of Substitute Caregivers (SCGs) to include but not limited to making prescribed medications available to residents. The PCG has provided extensive training to all Hale Lehua Carehome SCGs as required by Section 11-100.1-9. Personnel, staffing and family requirements (e) (4)</p> <p>Please see attached completed Primary Caregiver and Substitute Caregiver Training for SCG [REDACTED]. The PCG will continuously provide training and guidance to all staff about their duties and responsibilities.</p>	10/2/15
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.</p>	<p>[REDACTED]</p> <p>[REDACTED] In the future, any type of medication will not be left out inside the resident's room and/or bedside.</p> <p>Drugs are stored under proper conditions of sanitation,</p>	10/2/15

	<p>FINDINGS</p> <p>[REDACTED]</p>	<p>temperature, light, moisture, ventilation, segregation, and security as required under Section 11-100.1-15.</p> <p>On admission the resident's family or guardian will be informed that all medications will be ordered by a doctor and will be secured by staff.</p>	
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications. (e)</u> All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p>FINDINGS</p> <p>[REDACTED]</p>	<p>Section 11-100.1-15 Medications. (e) Plan of Corrections</p> <p>For future physician ordered medication (phone, fax or office visit), a copy of the medication order sheet will be obtained from the doctor. A list of the resident's medication will be provided to the doctor during office visit for update and approval by the doctor.</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>PCG to make sure that all new medications are labeled correctly and reflect doctor's medication and treatment orders. SCGs to cross check with medication sheets.</p> <p>In the future medication records should not be recorded in separate sheets when medication is changed or discontinued to avoid confusion. Notate all the changes on one medication sheet for the applicable month.</p> <p>When there are changes to medication as ordered by a physician, it will be noted immediately on the medication sheet and will be followed accordingly to avoid any error to occur.</p>	<p>11/4/15</p> <p>11/4/15</p> <p>10/2/15</p> <p>10/2/15</p> <p>10/2/15</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications. (h)</u></p>		

	<p>All telephone and verbal orders for medication shall be recorded immediately on the physician's order sheet and written confirmation shall be obtained at the next physicians visit and not later than four months from the date of the verbal order for the medication.</p> <p>FINDINGS </p>	<p>Section 11-100.1-15 Medications (h) Plan of Corrections All future telephone and verbal orders for medication will be recorded immediately on the Physician/APRN Record. Request the physician to approve and sign this sheet on the next office visit but not later than four months from the verbal order for medication.</p> <p></p>	<p>11/4/15</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications. (m)</u> 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.</p> <p>FINDINGS </p>	<p>PCG will remind all staff to document time of day if PRN is given. Resident's medication sheet shall indicate the time medication is given by SCGs and/or PCG.</p>	<p>10/2/15</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports. (b)(3)</u> During residence, records shall include:</p> <p>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;</p> <p>FINDINGS </p>	<p>Observations were conducted on resident's tolerance to "nectar liquids", need for and tolerance to Cipro, need for and effectiveness for PRN bisacodyl and docusate/Colase. These observations were communicated to the doctor and an order was made to advance diet to thin liquid. However, late entry was made on resident's record.</p> <p>The PCG will remind staff that monitoring of the resident's condition is important. Documenting their progress and changes in their condition is similarly important. PCG will monitor residents' progress reports every week to comply with the requirements of this section.</p>	<p>10/2/15</p>

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Licensee/Administrator's Signature:



Print Name: Romeo P. Valdez, Licensee

Date: November 9, 2015

Office of Health Care Assurance

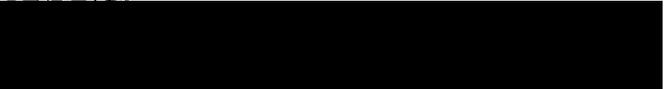
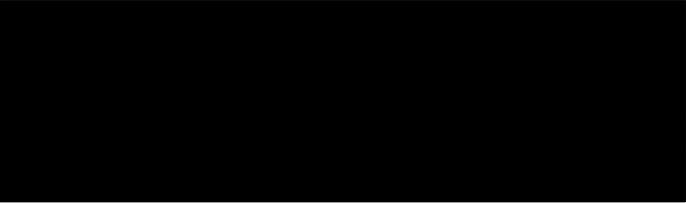
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	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p>FINDINGS [REDACTED] – No training by the primary care giver to make prescribed medication available to residents. Submit copy of training with the plan of correction (POC).</p>	<p>To prevent similar deficiencies from recurring the Primary Caregiver (PCG) will provide extensive training to all Substitute Caregivers (SCGs) as required by Section 11-100.1-9 prior to taking care of residents. In the future the PCG follows a checklist to ensure each SCG has proper training and documents once the SCG have mastered the skill/training provided. All SCG will demonstrate to make prescribed medications available to the residents and properly recorded after each administration to prevent any errors. The PCG will continuously provide training and guidance to all staff about their duties and responsibilities.</p> <p>Please see attached completed Primary Caregiver and Substitute Caregiver Training for [REDACTED]</p>	10/2/15
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.</p>	<p>[REDACTED] To prevent a similar deficiency from reoccurring, upon residents admission the resident's family or guardian will be informed that all medications will be ordered by the doctor and will be secured by staff. To ensure that medications are not left unsecured at bedside PCG/SCG will properly store residents medication after each administration and staff will frequently check the residents</p>	10/2/15

	<p>FINDINGS</p> <p>[REDACTED]</p>	<p>room for any medications left unsecured. Staff will also remind all family members/visitors not to bring any medications unless ordered by the doctor. In the future, any type of medication will not be left out inside the resident's room and/or bedside.</p>	
<p><input checked="" type="checkbox"/></p>	<p>§11-100.1-15 <u>Medications. (e)</u> All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p>FINDINGS</p> <p>[REDACTED]</p>	<p>Section 11-100.1-15 Medications. (e) Plan of Corrections</p> <p>[REDACTED] 11/4/15</p> <p>[REDACTED] A written confirmation is received next MD visit or within 4 months.</p> <p>If resident is doing well with diet an MD order to advance diet should be obtained first prior to starting new diet. The progress on how residents are tolerating diet order will be documented in progress note and all current MD orders will be followed. A list of the resident's medication/diet/activity will be provided to the doctor during office visit for update and approval by the doctor. All MD orders should be current and up to date.</p> <p>[REDACTED] 11/4/15</p> <p>In the future PCG/SCG will remind family members to obtain any orders/paperwork provided at the doctor appointment. Once MD orders/paper work received it is placed in residents chart. All telephone/verbal orders from MD will be recorded on MD order sheet and get written confirmation to next MD visit no longer than 4 months. In the future all medication are properly documented after each administration to ensure that all medications were given. All MD orders and documentation will be checked frequently by PCG weekly to prevent similar deficiencies.</p> <p>[REDACTED] 10/2/15</p> <p>[REDACTED] PCG to make sure that all new medications are labeled correctly and reflect doctor's medication and treatment orders. SCGs to cross check with medication sheets.</p> <p>[REDACTED]</p> <p>In the future when new medication are ordered/changed by MD, staff will promptly record new medication on residents medication sheet and will be followed accordingly to avoid any error. The right drug, dosage, route, and frequency of new medication will be checked and properly documented. All orders that are discontinued by MD will have "discontinued" and the date it was discontinued on med sheet. Med records should not be recorded in separate sheets when medication is changed or discontinued to avoid confusion. Notate all the changes on one medication sheet for the applicable</p>	<p>11/4/15</p> <p>11/4/15</p> <p>10/2/15</p> <p>10/2/15</p>
<p><input checked="" type="checkbox"/></p>	<p>§11-100.1-15 <u>Medications. (h)</u></p>	<p>month.</p>	

	<p>All telephone and verbal orders for medication shall be recorded immediately on the physician's order sheet and written confirmation shall be obtained at the next physicians visit and not later than four months from the date of the verbal order for the medication.</p> <p>FINDINGS</p> 	<p>Section 11-100.1-15 Medications (h) Plan of Corrections All future telephone and verbal orders for medication will be recorded immediately on the Physician/APRN Record. Request the physician to approve and sign this sheet on the next office visit but not later than four months from the verbal order for medication.</p>	<p>11/4/15</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p>FINDINGS</p> 	<p>To prevent similar deficiencies from reoccurring staff (PCG/SCG) will document immediately after administering medication to avoid any errors. PCG will train/frequently remind all staff proper documentation when administrating medication, which include time of day if PRN is given. In the future the resident's medication sheet shall indicate the time medication was given by SCGs and/or PCG.</p>	<p>10/2/15</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>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;</p> <p>FINDINGS</p> 	 <p>The PCG will remind staff that monitoring of the resident's condition is important. Documenting their progress and changes in their condition is similarly important. PCG will monitor residents' progress reports every week to comply with the requirements of this section.</p>	<p>10/2/15</p>

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Licensee/Administrator's Signature:

Print Name:

Date: 12/9/15