Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: AnoAno, L.L.C.	**CHAPTER 100.1**
Address: **54-2489 Kynnersley, Lot C, Kapaau, Hawaii 96755**	**Inspection Date: August 14, 2015 Annual**

	Rules (Criteria)	**Plan of Correction**	**Completion Date**
☒	§11-100.1-9 Personnel, staffing and family requirements. (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. **FINDINGS** SCG [redacted] SCG [redacted] – No annual examination to certify that they are free from communicable disease. **Submit a copy for each with the plan of correction (POC).**		
☒	§11-100.1-10 Admission policies. (a) Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be obtained prior to a resident's admission to a Type I ARCH		

	and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's responsible placement agency, and others authorized by the resident to review it. **FINDINGS** Resident [redacted] – No level of care assessment at the time of readmission [redacted]		
☒	§11-100.1-11 Activities of daily living. The licensee shall provide personal care, shelter, protection, supervision, assistance, guidance or training, planned activities, food service, laundering of personal clothing, recognition of and provision for changes in health status, and arrangement for transportation to medical and dental offices. **FINDINGS** [redacted]		
☒	§11-100.1-12 Emergency care of residents and disaster preparedness. (b) The licensee shall maintain a first aid kit for emergency use for each Type I ARCH. **FINDINGS** First aid kit contained single use antibiotic ointment packages, no triangle bandage.		
☒	§11-100.1-13 Nutrition. (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit.		

	FINDINGS Resident [redacted] - No diet order [redacted]		
☒	§11-100.1-14 Food sanitation. (c) Refrigerators shall be equipped with an appropriate thermometer and temperature shall be maintained at 45°F or lower. **FINDINGS** Refrigerator thermometer reflected 70° F. The thermometer was broken.		
☒	§11-100.1-15 Medications. (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. **FINDINGS** "Detoxificant" was unsecured in the refrigerator.		
☒	§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]		
☒	§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]		
☒	§11-100.1-16 Personal care services. (j) Resident(s) manifesting behaviors that may cause injury to self or others shall be assessed by a physician or APRN to determine least restrictive alternatives to physical restraint use, which may be used only in an emergency when necessary to protect the resident from injury to self or to others. If restraint use is determined to be required and ordered by the resident's physician or APRN, the resident and the resident's family, guardian or surrogate, and case manager shall be notified and a written consent obtained. The licensee shall maintain a written policy for restraint use outlining resident assessment processes, indications for use, monitoring and evaluation and training of licensee and substitute care givers. Renewal orders for restraint use shall be obtained on a weekly basis from the resident's physician or APRN based on the assessment, monitoring and evaluation data presented by the primary care giver. **FINDINGS** [redacted]		

	[redacted]		
☒	§11-100.1-17 Records and reports. (a)(4) 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: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident [redacted] - No report of medical examination for [redacted]		
☒	§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** Resident [redacted] - No signed physician orders [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** Resident [redacted] – Progress notes did not reflect [redacted] Resident [redacted] – No progress notes that the primary care giver and physician was made aware [redacted] Resident [redacted] – No progress notes of actions taken [redacted] [redacted] Resident [redacted] however, no documentation that the recommendation was followed.		
☒	§11-100.1-17 Records and reports. (c)		

	Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary. **FINDINGS** Resident [redacted] – No incident report initiated [redacted] No incident report for the resident [redacted] No incident report(s) for staff on duty physically hurt by [redacted] that was noted in the progress notes.		
☒	§11-100.1-20 Resident health care standards. (c) The primary and substitute care giver shall be able to recognize, record, and report to the resident's physician or APRN significant changes in the resident's health status including, but not limited to, convulsions, fever, sudden weakness, persistent or recurring headaches, voice changes, coughing, shortness of breath, changes in behavior, swelling limbs, abnormal bleeding, or persistent or recurring pain. **FINDINGS** Resident [redacted] - Staff failed to notify the physician of the resident's behavior [redacted] Resident [redacted] – Staff failed to notify the physician [redacted]		

☒	§11-100.1-20 Resident health care standards. (d) When the resident has experienced a significant change in mental or physical well-being, a prompt report shall be made and provided to the resident's physician or APRN, by the primary or substitute caregiver. Any change in physician or APRN orders shall be promptly carried out. **FINDINGS** Resident [redacted] - Staff failed to notify the physician of the resident's behavior [redacted] Resident [redacted] Staff failed to notify the physician when the resident [redacted]		
☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(2)(D) Residents' rights and responsibilities: Each resident shall: Physical restraints may only be used in an emergency when necessary to protect the resident from injury to self or to others. In such a situation the resident's physician or APRN shall be notified immediately to obtain an assessment for least restrictive alternatives to restraint use. If restraint use is determined to be necessary, written orders shall be obtained from the resident's physician or APRN indicating the form of restraint to be used, the length of time restraint shall be applied, the frequency of use and the alternative care that can be provided to the resident. If a less restrictive alternative to restraint exists, it must be used in lieu of the restraint. The resident's family, legal guardian, surrogate or representative, and case manager shall be notified if no alternative to restraint exists and a written consent shall be obtained for restraint use. The restraint use shall be in		

	compliance with the Type I ARCH's written policy, as approved by the department; **FINDINGS** [redacted]		
☒	§11-100.1-23 Physical environment. (g)(3)(I) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either: **FINDINGS** Resident [redacted] – No self-preservation certification [redacted]		
☒	§11-100.1-23 Physical environment. (o)(3)(B) Bedrooms: Bedroom furnishings: Each bed shall be supplied with a comfortable mattress cover, a pillow, pliable plastic pillow protector, pillow case, and an upper and lower sheet. A sheet blanket may be substituted for the top sheet when requested by the resident;		

	FINDINGS One pillow for each of five (5) resident beds did not have a pliable plastic pillow protector.		

Licensee/Administrator's Signature: _____

Print Name: _____

Date: _____