

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

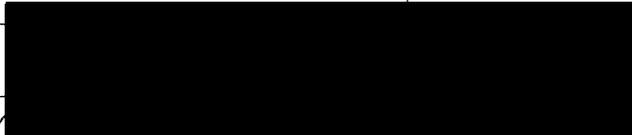
Facility's Name: The Arc in Hawaii – Waipahu A (DDDH)	CHAPTER 89
Address: 94-060 A Poailani Circle, Waipahu, Hawaii 96797	Inspection Date: August 12, 2015 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (e)(6) Medications:</p> <p>All physician orders shall be re-evaluated and signed by the physician every three months or at the next physician's visit, whichever comes first.</p> <p>FINDINGS [REDACTED]</p>	See Attachment 1	
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (e)(11) Medications:</p> <p>Discontinued or outdated medications shall be disposed of by flushing down the toilet.</p> <p>FINDINGS [REDACTED]</p>	See Attachment 1	

	Rules (Criteria)	Plan of Correction	Completion Date
	[REDACTED]		
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (e)(12) Medications:</p> <p>All medications and supplements, such as vitamins, minerals, and formulas, shall have written physician's orders and shall be labeled according to pharmaceutical practices for prescribed items. When taken by the resident, the date, time, name of drug, and dosage shall be recorded on the resident's medication record and initialed by the certified caregiver.</p> <p>FINDINGS</p> <p>[REDACTED]</p>	<p>See Attachment F</p>	
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (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 submitted to the case manager within twenty-four hours from the time of the incident and shall be retained by the facility under separate cover, and shall be made available to the</p>		

	Rules (Criteria)	Plan of Correction	Completion Date
	<p>department and other authorized personnel. The resident's physician shall be called immediately if medical care is necessary.</p> <p>FINDINGS</p> 	<p>See Attachment 1</p>	
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (e)(1) General rules regarding records:</p> <p>All entries in the resident's records shall be written in blue or black ink, or typewritten, shall be legible, dated, and signed with full signature and title by the individual making the entry;</p> <p>FINDINGS</p> 	<p>See Attachment 1</p>	
<input checked="" type="checkbox"/>	<p>§11-89-19 <u>Nutrition.</u> (o) Special diet orders shall be updated every three months by a physician. Verbal orders for special diets shall be recorded on the physician order sheet by the caregiver receiving the verbal orders and written confirmation by the attending physician shall be obtained at the next office visit.</p>		

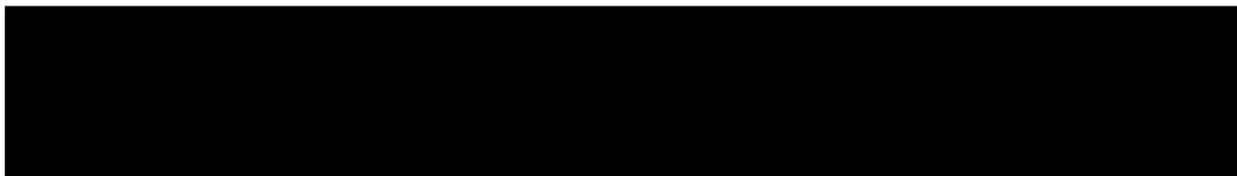
	Rules (Criteria)	Plan of Correction	Completion Date
	FINDINGS 	See Attachment 1	

Licensee's/Administrator's Signature: 

Print Name: CHRISTINE MORALES

Date: 9/4/15

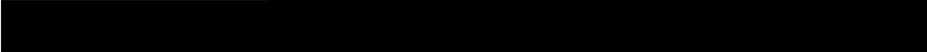
Comments/Advisements



§11-89-14 Residential health and safety standards. (e)(6)

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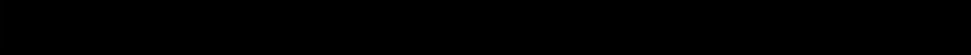
Plan of Correction:


 The home manager received in service training from the Director of Nursing regarding verification of orders on the 90 day review. The Director of Nursing will provide oversight and conduct random audits of the client records and make written recommendations for changes and corrections.  will follow up on the corrections with the home manager and appropriate staff members. **Date of Completion:** September 4, 2015

§11-89-14 Resident health and safety standards. (e)(11)

Page 1

Plan of Correction:


 Staff will continue to check medication when it comes to the home and will refuse those with hand written dates that are not precise. The Director of Nursing will provide oversight and conduct random audits of the client records and make written recommendations for changes and corrections. She will follow up on the corrections with the home manager and appropriate staff members. **Date of Completion:** August 12, 2015

§11-89-14 Resident health and safety standards. (e)(12)

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Plan of Correction: The error was corrected on site. The home manager received in service training regarding doing thorough checks of the medication record for documentation. [REDACTED] 30-minute checks of the medication record are currently instituted and will continue to be done per protocol. The Director of Nursing will provide oversight and conduct random audits of the client records and make written recommendations for changes and corrections. She will follow up on the corrections with the home manager and appropriate staff members.

Plan of Corrections: [REDACTED]

[REDACTED] The home manger received in service training from the Director of Nursing regarding checking and rechecking printed visit notes for accuracy prior to leaving the office including getting the errors corrected. [REDACTED] The Director of Nursing will provide oversight and conduct random audits of the client records and make written recommendations for changes and corrections. She will follow up on the corrections with the home manager and appropriate staff members. **Date of Completion:** September 4, 2015

§11-89-18 Records and reports. (c)

Page 2 and 3

Plan of Correction: [REDACTED]

[REDACTED] Annually the Programs and Services Assistant will compile copies of all incident reports that were generated by the home and have them available for the home manager. The home manager will look through the incident reports that they have on file in the home and utilize the copies from the Administration Office should they be missing their own copy. This will ensure all incidents that were reported throughout the year is available. **Date of Completion:** September 16, 2015

