

Office of Health Care Assurance

State Licensing Section

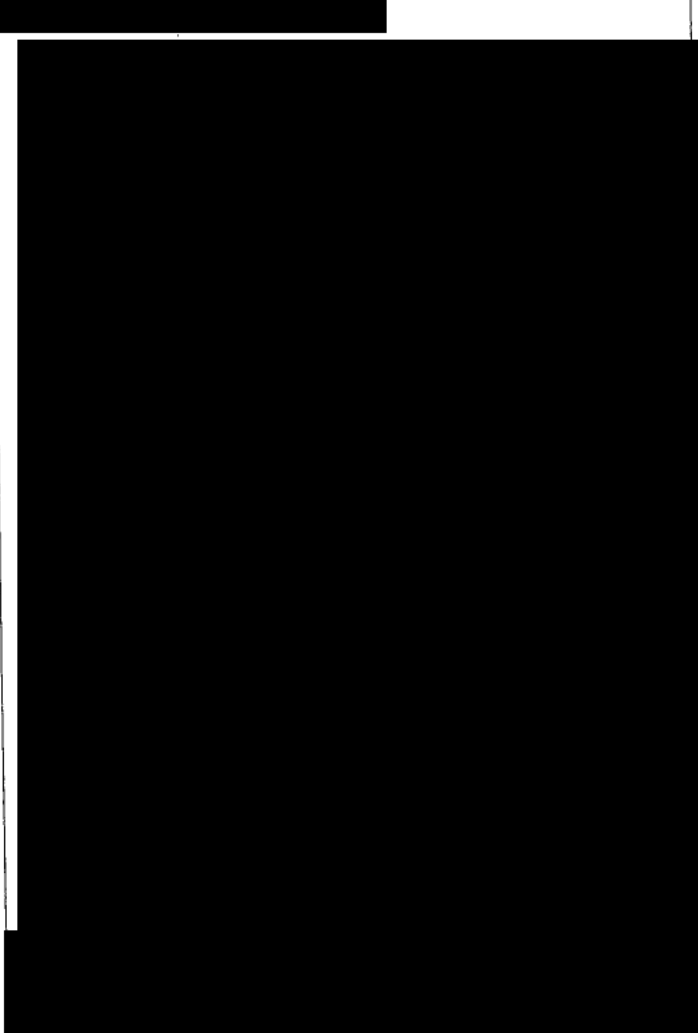
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: ARC of Maui County – Molokai Residence Hale Maunaloa (DDDH)	CHAPTER 89
Address: 24 Hoalua Street, Maunaloa, Hawaii 96770	Inspection Date: October 23, 2015 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-9 <u>General staff health requirements.</u> (a)(1) All individuals living in the facility including those who provide services directly to residents shall have documented evidence that they have had examination by a physician prior to their first contact with the residents of the home and thereafter as frequently as the department deems necessary. The examination shall be specifically oriented to rule out communicable disease and shall include tests for tuberculosis.</p> <p>If an initial tuberculin skin test is negative, a second tuberculin skin test shall be done after one week, but no later than three weeks after the first test. The results of the second test shall be considered the baseline test and shall be used to determine appropriate treatment follow-up. If the second test is negative, it shall be repeated once yearly thereafter unless it becomes positive.</p> <p>FINDINGS A current TB clearance was not available for Staff #1.</p>	<p><i>See attached</i></p>	<p><i>2/16/16</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
	(NOTE: A copy was received on October 30, 2015.)		
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (d)(3) The caregiver shall develop an emergency evacuation plan to ensure rapid evacuation of the facility in the event of fire or other life-threatening situations. The plan shall be posted and shall include a provision for evacuation drills as follows:</p> <p>Each resident of the facility shall be certified annually by a physician that the resident is capable of self-preservation. A maximum of two residents not so certified may reside in the facility provided that a staff ratio of one-to-one is maintained, at all times, for each of these residents and there are no stairways which must be negotiated by such noncertified residents. As an alternative, the facility shall install an automatic sprinkler system, as defined in the national fire protection association's 101 life safety code.</p> <p>FINDINGS For Resident #3, the [REDACTED] Statement was not completed until [REDACTED], although resident was admitted on [REDACTED].</p> <p>Residents #2 and #3 were admitted to the DDDH [REDACTED] [REDACTED], respectively. Both residents are not able to [REDACTED]; however, 1:1 coverage is not consistently provided, especially at night. Although the facility is equipped with a fire sprinkler system, it did not pass its annual inspection, as noted on the Automatic Sprinkler System – Inspection Record of April 21, 2015. (NOTE: Please submit a copy of a satisfactory automatic sprinkler system report or of a staffing schedule to verify that 1:1 coverage is being provided when both residents are in the DDDH.)</p>	<p><i>See attached</i></p>	<p><i>2/16/16</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (e)(5) Medications:</p> <p>All medications and supplements, such as vitamins, minerals, and formulas shall be made available by written physician order and shall be based upon current evaluation of the resident's condition.</p> <p>FINDINGS For Resident #1, there was no admission order for [REDACTED] Resident was admitted [REDACTED]; however, the order was not obtained until [REDACTED].</p> <p>For Resident #1, there was no physician order [REDACTED]</p> <p>For Resident #1, there was no physician order [REDACTED]</p>	<p><i>See attached</i></p>	<p><i>2/16/16</i></p>
<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 [REDACTED]</p>	<p><i>See attached</i></p>	<p><i>2/16/16</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
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	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (a)(1) Individual records shall be maintained for each resident. Upon admission or readmission, the facility shall maintain:</p> <p>Records which identify the resident's name, social security number, marital status, date of birth, sex, next of kin or guardian, and religious preference, if any. A record of the address and telephone number of the referral agency or source by which the resident was admitted, the attending physician, dentist, and other medical or social service professionals who are currently involved in providing services to the resident, as well as a record of the agency responsible for financial payment, and the medical insurance plan;</p>	<p><i>See attached</i></p>	<p><i>2/16/16</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
	<p><u>FINDINGS</u> Caregiver entries for all residents were written in one composition book and not in each resident's respective medical record.</p>		
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (a)(2) Individual records shall be maintained for each resident. Upon admission or readmission, the facility shall maintain:</p> <p>A report of a medical examination current to within nine months and current diagnosis, physician's orders for medication, diet, special appliances and equipment, treatment, evaluations or direct service to be provided by a physical therapist, occupational therapist, or speech pathologist and a report of an examination for tuberculosis performed within the year prior to admission, height and weight and medical history;</p> <p><u>FINDINGS</u> For Resident #1, there was no verification that a two-step TB skin test was done, prior to admission. Evidence of only a single TB skin test, done on [REDACTED], was on file.</p> <p>For Resident #2, a chest x-ray was completed on [REDACTED] however, there was no verification of a positive TB skin test. The TB clearances prior to that indicate negative TB skin tests on [REDACTED].</p> <p>For Resident #3, there was no verification of a current TB skin test. The TB skin test on file was dated [REDACTED].</p> <p>Resident #3 was admitted to the DDDH [REDACTED]; however, [REDACTED] physical examination was not completed until [REDACTED].</p>	<p><i>See attached</i></p>	<p><i>2/16/16</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
	[REDACTED]		
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (b)(2) During residence, records shall be maintained by the caregiver and shall include the following information:</p> <p>Observations of the resident's response to medication, treatments, diet, provision of care, response to activities programs, indications of illness or injury, unusual skin problems, changes in behavior patterns, noting the date, time and actions taken, if any, which shall be recorded monthly or more often as appropriate but immediately when an incident occurs;</p> <p>FINDINGS</p> <p>[REDACTED]</p>	<p><i>See attached</i></p>	<p><i>2/16/16</i></p>
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (b)(7) During residence, records shall be maintained by the caregiver and shall include the following information:</p> <p>Recording of resident's weight at least once a month, and more often when requested by a physician;</p> <p>FINDINGS</p> <p>For Resident #1, there were no documented weights for [REDACTED]</p>	<p><i>See attached</i></p>	<p><i>2/16/16</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
	[REDACTED]		
<input checked="" type="checkbox"/>	§11-89-18 <u>Records and reports.</u> (e)(2) General rules regarding records: Erasures and white outs shall not be permitted; <u>FINDINGS</u> For Resident #1, white out was used on the [REDACTED] medication record.	See attached	2/16/16
<input checked="" type="checkbox"/>	§11-89-18 <u>Records and reports.</u> (g)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; <u>FINDINGS</u> An admission/discharge registry was not available for review.	See attached	2/16/16

Licensee's/Administrator's Signature: [Signature] / [Signature]
 Print Name: Robert Lane / VALERIE SY
 Date: 2/16/2016

Licensee's/Administrator's Signature: [Signature] / [Signature]
 Print Name: Robert Lane / VALERIE SY
 Date: 3-15-16

ARC of Maui County
Hale Maunaloa
Plan of Correction
February 2016

Annual Inspection: 10/23/15

Completion Dates: All corrective actions listed below are **effective February 16, 2016**

• **Rule (Criteria)**

11-89-9 General staff health requirements (a)(1)

Findings: A current TB clearance was not available for Staff #1

Corrective Action:

Staff #1 is an agency RN and provides a range of services for the agency. [REDACTED] TB clearance was located in the agency office and was not available for review with the other staff certifications. To correct this issue, a copy of Staff #1 TB clearance is now on file and available at the residence.

To prevent recurrence of this issue, the Resident Manager was retrained on the general staff health requirements; specifically that documentation of TB clearances for individuals living in the residence and those who provide services to residents, will be maintained within the residence and will be made available as appropriate.

ARC of Maui County
Hale Maunaloa
Plan of Correction Revisions
March 2016

Annual Inspection: 10/23/15

Completion Dates: All corrective actions listed below are **effective February 16, 2016** (unless otherwise specified).

• **Rule (Criteria)**

11-89-14 Resident health and safety standards (d)(3)

Corrective Action:

Resident #3 was transferred from a residential facility on Oahu. The Resident Manager made repeated requests to the resident's Program Manager and DOH Case Manager for the required documentation prior to admission into Hale Maunaloa, but was unable to obtain the information. The Program Manager stated that [REDACTED] would have the documentation sent with the resident upon transfer to Molokai, but did not follow through.

The Resident Manager scheduled an appointment with a health care provider as soon as possible on [REDACTED] and received the [REDACTED] statement for Resident #3, which documented that the resident was not [REDACTED]. This document was obtained from an APRN who stated that [REDACTED] did not have enough information about the resident or the definition of [REDACTED]. Resident # 2 and Resident #3 were taken to a new MD who understood the definition of [REDACTED] and documented that **Resident #2 and Resident #3 were both** [REDACTED].

To correct this issue, the Resident Manager was retrained on the requirement for a self-preservation statement for residents prior to admission.

The automatic fire sprinkler system inspection report states that the alarm did not sound. The inspector did not give advanced notice of their inspection and the Resident Manager was not present. Advanced Fire Protection completes their inspections on Molokai annually and inspects numerous facilities on the island the same day. They will not return to Molokai until April 2016.

In the interim, the General Contractor for Hale Maunaloa, from Lehua Services, met with the Resident Manager at Hale Maunaloa on 2/12/16. They spoke with the Advanced Fire Protection manager and followed [REDACTED] advice on how to inspect the sprinkler system. The alarm was retested and sounded with a beeping sound rather than a siren alarm (which Advanced Fire Protection expected). The beeping sound was barely audible when the door was closed. The contractor then spoke with Interlogix Fire and Security Company, who informed [REDACTED] that the alarm system was set to make a beeping sound when the sprinkler system is inspected as opposed to a siren sound. This is because the control valves are located outside in an unsupervised location. Based on information from Interlogix, the alarm setting was changed and when retested, the siren alarm sounded rather than the beeping sound. It is expected that Hale Maunaloa will pass the 2016 inspection as a result of resetting the alarm system to sound to their specifications.

Advanced Fire Protection was contacted 3/14/16 to confirm their estimated inspection timeframe. They stated that their inspections for Molokai would take place by the end of April, 2016, if not before. A new automatic fire sprinkler system inspection report will be submitted to Office of Health Care Assurance after the inspection is completed.

As a result of Resident #2 and Resident #3 being classified as [REDACTED], the need for a satisfactory automatic sprinkler system report or a staffing schedule to verify 1:1 coverage is not required at this time. Should circumstances change; the requested documentation will be provided.

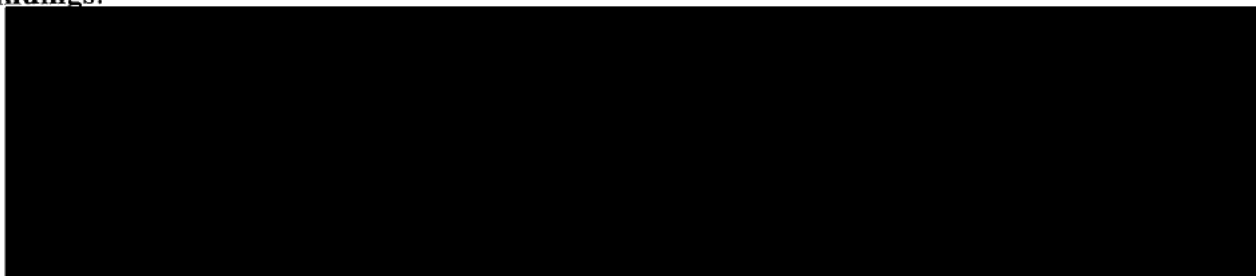
To prevent recurrence of this issue, the Resident Manager was retrained on the requirement for obtaining needed documentation for residents prior to or on the day of admission. The facility has obtained documentation regarding the definition of [REDACTED] that will be provided to a physician for purposes of assessing residents' [REDACTED] capabilities. Additionally, the Resident Manager will be required to submit the annual automatic fire system sprinkler inspection report to the administrator for review so any issues can be addressed in a timely manner.

- **Rule (Criteria)**

11-89-14 Resident health and safety standards (e)(5)

Medications:

Findings:



Corrective Action:

Until the Hale Maunaloa residence opened, and per guardian approval, Resident #1 was living in the home of an Arc of Maui waiver staff who agreed to provide temporary housing for the resident. The staff became certified as a Responsible Adult at Hale Maunaloa when Resident #1 was admitted, and [REDACTED] continued to work with the resident.

During the time when the resident resided with the staff, [REDACTED] developed routines of care and relationships with the resident's health care providers. [REDACTED] continued to accompany the resident to appointments and obtain medications. The Resident Manager had numerous documented issues with this staff in regard to follow through on required documentation which included obtaining physician orders, and the staff was discharged in [REDACTED].

[REDACTED] To correct this issue, the Resident Manager was retrained by the agency RN on the requirement for a physician's order prior to dispensing medication (OTC, PRN or otherwise). In addition, the Resident Manager was retrained by the administrator regarding the responsibility of oversight of staff in the residence and oversight of the resident medication requirements.

To prevent recurrence of this issue, staff in the residence was retrained by the agency RN on the physician's order process. All residents' medications were reviewed to ensure medications correspond to the physician orders, and physician orders were obtained for medications without a corresponding order.

- **Rule (Criteria)**

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

Findings:

[REDACTED]

Corrective Action:

The discrepancies with the October, 2015 MAR for the PRN medications were corrected. The Resident Manager was retrained by the agency RN regarding the requirement for the MAR, the physician's order, and the pharmacy label to correlate with each other for all medications including OTC and PRN medications. This practice will ensure the implementation of the "five rights of medication administration" and resident safety.

To correct the issues with improper recording on the MAR, the staff identified in one of these incidents was retrained on the required documentation; specifically in regard to initialing the MAR after medications are given. The other staff who improperly recorded information on the MAR was dismissed as a result of this and other issues, and is no longer working at Hale Maunaloa.

In review of the issue regarding the [REDACTED] medication for Resident #1; the medication was increased by the MD; however, a new physician's order was not obtained. The medication is no longer prescribed for the resident. To correct this issue, the Resident Manager was retrained by the agency RN on the requirement to obtain a physician's order prior to the dispensing of any medication (OTC or otherwise).

In review of the issue regarding the May, 2015 MAR not reflecting the frequency and dose of the medications listed or times given; the Resident Manager failed to include this information when the new MAR was developed for the month in question. To correct this issue, the Resident Manager was retrained by the agency RN on the required information to be included on the MAR to ensure the "five rights of medication administration".

To prevent recurrence of these issues, the agency RN provided a medication re-training for all residence staff which included:

- Procedures for obtaining a physician's order;
- Ensuring the MAR, the physician's order and the pharmacy labels correlate for all medications, including OTC and PRN medications;
- Proper documentation requirements for the MAR and;
- Recording responses to new and PRN medications in the Caregiver Notes.

To monitor these corrective actions, the agency RN will review monthly, for a period of three months, the correct medication procedures for all residents.

In addition, the medications are now dispensed by the pharmacy in Blister-Paks. The Resident Manager is currently in discussion with the pharmacy to have the MAR printed by them or for them to review the MARS each month to ensure they coincide with the pharmacy labels and physician's orders. These steps are intended to decrease the potential for medication errors.

- **Rule (Criteria)**

11-89-18 Records and reports, (a)(1)

Findings: Caregiver entries for all residents were written in one composition book and not in each resident's respective medical record.

Corrective Action:

Caregiver entries were written in a composition book which was kept in the office, and utilized to facilitate communicating specific and general information to other staff. The communication log was designed to support staff and to encourage continuity of care and information-sharing between staff.

Staff failed to document required resident information in the "Caregiver Notes" and instead they were documenting this information in the communication log. In addition, the "Caregiver Notes" form should have been located in the residents' individual medical record.

To correct this issue, the Resident Manager and the staff were retrained to document required resident information on the "Caregiver Notes" form and the form is now located in the respective resident's medical record.

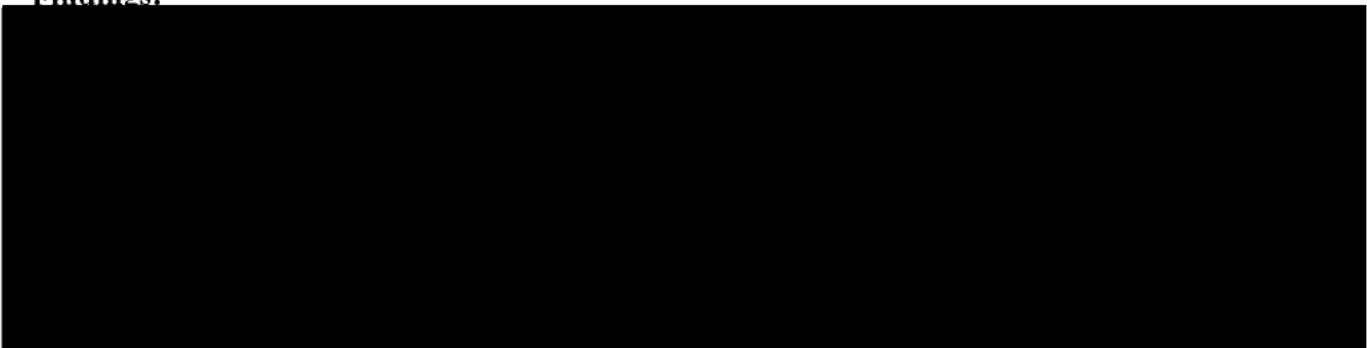
Staff will continue to utilize the composition book for general information-sharing, and as an important means of communicating with staff that do not have the opportunity to discuss and share information face-to-face, and to share information during shift changes.

To prevent recurrence of this issue, the Resident Manager and the staff were retrained. To monitor this corrective action, the Resident Manager will review with the Program Director the correct implementation of the Caregiver Notes for all residents, monthly for a period of three months to ensure the required information is documented.

- **Rule (Criteria)**

11-89-18 Records and reports, (a)(2)

Findings:



Corrective Action:

Resident #1: The Resident Manager understood that a two-step TB skin test was required for staff working at the residence; however, [REDACTED] was not aware that a two-step TB skin test was required for residents. As a result, only a single TB skin test was completed for resident #1. To correct this issue, a second step TB skin test was obtained. [REDACTED]

To prevent recurrence of this issue, the Resident Manager was retrained on the requirement for residents to obtain a two-step TB skin test prior to admission to the residence.

Resident #2: The circumstances under which Resident #2 was moved from [REDACTED] home on the Big Island to the residence on Molokai were extenuating. [REDACTED] family did not have medical records and the case manager could not locate any records, because [REDACTED] had not been receiving services for an extended amount of time. Arc of Maui obtained minimal information over the course of several weeks, although a considerable amount of information was never provided. Arc of Maui received a chest x-ray, which was completed before admission to the residence. A current negative TB skin test was not obtained. To correct this issue, a two-step TB skin test was obtained for Resident #2. [REDACTED]

To prevent recurrence of this issue, the Resident Manager was retrained on the requirement for residents to obtain a two-step TB skin test prior to admission to the residence.

Resident #3: Regarding the two-step TB skin test and the physical examination for the resident; the resident was transferred from a residential facility on Oahu and the Hale Maunaloa Resident Manager had been assured that the information in question was to be provided prior to admission.

Prior to the resident's admission, repeated attempts were made to obtain the information from the resident's Program Manager and DOH Case Manager on Oahu, however, some documentation was never obtained.

To correct this issue, the Resident Manager scheduled and obtained a two-step TB skin test, completed on [REDACTED] and completed a physical examination on [REDACTED]

To prevent recurrence of this issue, the Resident Manager was retrained on the requirement for residents to obtain a two-step TB skin test and a physical examination prior to admission to the residence.

- **Rule (Criteria)**
11-89-18 Records and reports, (b)(2)

Findings:

[REDACTED]

Corrective Action:

To correct these issues for Resident #1, staff was retrained regarding the requirement for documenting residents' responses to new or PRN medications in the Caregiver Notes.

To prevent recurrence of this issue, the agency RN provided a medication re-training for all residence staff which included the requirement for recording responses to new and PRN medications in the Caregiver Notes. To monitor this corrective action, the Resident Manager will review the MAR and the Caregiver Notes monthly for a period of three months to ensure staff is documenting resident responses to new or PRN medications.

- **Rule (Criteria)**
11-89-18 Records and reports, (b)(7)

Findings: For Resident #1, there were no documented weights for [REDACTED]

Corrective Action:

To correct this issue and prevent its recurrence, the Resident Manager was retrained on the requirement for checking and recording residents' weight at least once per month, and more often when requested by a physician, and maintaining this information in the clients' medical records. The Resident Manager retrained staff regarding obtaining and recording monthly weight checks, and will review resident files monthly to ensure staff obtain monthly weight checks for residents.

- **Rule (Criteria)**

11-89-18 Records and reports, (c)(2)

Findings: For Resident #1, white out was used on the [REDACTED] medication record.

Corrective Action:

To correct this issue and to prevent its recurrence, the Resident Manager was retrained on the guidelines for modifying information on the medication and other records; specifically that the use of White Out and erasures is strictly prohibited. White out was removed from the office.

Additionally, the Resident Manager retrained staff on the general rules regarding the modification of records, and directed staff to discontinue the use of erasures and White Out.

- **Rule (Criteria)**

11-89-18 Records and reports, (g)(1)

Findings: An admission/discharge registry was not available for review.

Corrective Action:

To correct this issue and to prevent its recurrence, the Resident Manager established an Admission/Discharge Registry and generated entries on the admissions of the three residents. It is now located in a locked cabinet that contains resident medical records. The Resident Manager was retrained on the guidelines for miscellaneous records; specifically that a general registry must be maintained wherein admissions and discharges of residents are recorded. The Resident Manager trained staff on the utilization of the Admissions/Discharge Registry.