

Office of Health Care Assurance

State Licensing Section

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STATE OF HAWAII
DOH-OHCA LICENSING

Facility's Name: Aginaldo's	CHAPTER 100.1
Address: 4406 Likini Street, Honolulu, Hawaii 96818	Inspection Date: May 3, 2016 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (d) Current menus shall be posted in the kitchen and in a conspicuous place in the dining area for the residents and department to review.</p> <p><u>FINDINGS</u> Menu was not posted in the kitchen.</p>	<p><i>I make sure menu is posted in the kitchen and dining area. I have to check every week when I change the menu that it is posted</i></p>	<p><i>5/3/16</i></p>
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation</u>. (c) Refrigerators shall be equipped with an appropriate thermometer and temperature shall be maintained at 45°F or lower.</p> <p><u>FINDINGS</u> Temperature in refrigerator located outside the facility was 52° F.</p>	<p><i>I have to check the refrigerator every week to make sure that the temp. is 45° always, when cleaning the refrigerator.</i></p>	<p><i>5/3/16</i></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</p>		

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	<p>security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.</p> <p>FINDINGS Resident #1 – Medication basket dirty. Contained a layer of [redacted] on the bottom of the basket.</p>	<p>All resident's medication baskets have been thoroughly cleaned & sanitized. Going forward all medication basket will be cleaned monthly to ensure proper sanitary conditions for residents' medications.</p>	<p>5/4/16</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 Resident #1 – [redacted] was not initialed as given [redacted].</p>	<p>PCG missed to initial war [redacted] but med. was given. PCG will double check administration at all times</p>	<p>5/3/16</p>
		<p>To prevent future occurrences, teaching has been provided that caregivers to ensure that all dispensed meds. shall be properly initialed on MAR at time given to residents. Also to prevent this from happening, weekly audits of the MAR will be done by CTR to ensure that MAR is being completed accurately.</p>	
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(1) 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:</p> <p>Documentation of primary care giver's assessment of resident upon admission;</p> <p>FINDINGS Resident #1 – No admission assessment at the time of readmission [redacted].</p>	<p>Going forward, an admission/readmission checklist has been created and attach to each file to ensure that proper documentation is completed when a new resident of current resident is admitted into the care home. CTR must complete checklist</p>	<p>5/3/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (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:</p> <p>Physician or APRN signed orders for diet, medications, and treatments;</p> <p>FINDINGS Resident #1 – No signed physician orders for medication at the time of readmission [REDACTED].</p> <p>Resident #1 – Physician order for [REDACTED] was not clarified to specify the consistency.</p>	<p>An admission packet has been pull together which includes: Resident P.E. exam, physician order sheet, level of care, self preservation needs and vaccination record. This will provide proper documentation whenever a new or current resident is admitted/readmitted into the care home. CTO will ensure that these documents are completed prior to resident being admitted/readmitted to the care home.</p> <p>To ensure that modified liquid consistency is completed, CTO will double check physician order sheet to ensure the proper liquid consistency is documented by including a check box on the order sheet to include: thin, honey or nectar consistency.</p>	
		<p>Resident went back to MD after [REDACTED] but PCG forgot to bring order to be signed, PCG will make sure that MD will sign orders every visit.</p> <p>Always ask the MD to specify the consistency of thickened liquid and have it write in the order.</p>	<p>5/16/16</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<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 Resident #1 – Progress notes did not reflect:</p> <ul style="list-style-type: none"> • [redacted] order [redacted] was not provided because the primary care giver (PCG) stated resident "didn't need it" and "didn't like it." • Tolerance to [redacted] nutritional supplement [redacted] PCG stated the resident is able to consume the two [redacted] ordered. • Resident needs assistance with meals [redacted] 	<p>PCG will have a daily documentation as to ensure compliance with any refusal of meds./other orders, need of [redacted] BM in 2-3 days meal assistance through the daily flow sheet provided to PCG by CMA.</p> <p>I had a meeting with CMA discussed the areas of concern regarding progress notes. [redacted] stated [redacted] will address these concerns in [redacted] progress notes or monthly visit notes and I will document my progress notes also. In the future I will seek all [redacted] progress notes to make sure in future I provide to [redacted] as well as [redacted] assessment and assessment are documented in the progress notes.</p>	<p>5/10/14</p>
		<p>Going forward, at time of change in condition CMA will ensure to document in progress notes any and all changes (meds. changes, treatments, diet, care plans, illness/injury, behavior changes) at time of occurrence or changes. And when completing the monthly progress notes sheet this will add as a double check to ensure that the changes are reflected and the resident's response to the changes are properly documented. And quarterly [redacted] chart audit will be done by CMA to ensure proper documentation is complete and accurate.</p>	

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(4) During residence, records shall include:</p> <p>Entries describing treatments and services rendered;</p> <p>FINDINGS Resident #1 - [redacted] order [redacted] was not clarified and provided. There was no documentation that the resident "didn't need it" and "didn't like it" as reported by the primary care giver.</p>	<p><i>recommends fin from the hospital to have liquid but Resident refused to take. PCG will make sure that MD notified of such refusal and to document and obtain order. Order will be obtained by PCG from MD to d/c [redacted] liquid</i></p>	<p>5/11/14</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-86 <u>Fire safety.</u> (a)(2) A Type I expanded ARCH shall be in compliance with existing fire safety standards for a Type I ARCH, as provided in section 11-100.1-23(b), and the following:</p> <p>Resident's sleeping room doors shall be self closing;</p> <p>FINDINGS One (1) expanded arch resident, bedroom door did not close completely into the door jamb.</p>	<p><i>The door was fixed and closed all the way when I make sure to check the door every month when I do the fire drill.</i></p>	<p>5/4/14</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(4) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Update the care plan as changes occur in the expanded ARCH resident care needs, services and/or interventions;</p> <p>FINDINGS</p>	<p><i>To prevent future concerns, a check list has been created to for case manager to complete on their on their monthly visits which includes a check that for case manager to ensure that all changes are reflected on the resident's care plan. And to ensure this is being done the case manager + CTO must sign and date the checklist to ensure proper completion.</i></p>	

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	[REDACTED]	I have discussed with the case manager to effect [REDACTED] liquid in the service plan due to no use/affirm. obtained from PID	5/11/14
	[REDACTED]	to do [REDACTED] liquid. Blood pressure parameters for [REDACTED] attention is on foot.	
	[REDACTED]	altered antibiotic [REDACTED] PCG will make sure to notify CH	

to up date service plan

Licensee's/Administrator's Signature: Serafina Aguilardo

Print Name: SERAFINA AGUILARDO

Date: 5/20/14

Licensee's/Administrator's Signature: Serafina Aguilardo

Print Name: SERAFINA AGUILARDO

Date: 7/6/14