

Office of Health Care Assurance

State Licensing Section

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Callo Care Home	CHAPTER 100.1
Address: 1027A Lowell Place, Honolulu, Hawaii 96817	Inspection Date: January 13, 2016 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<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 Resident #1 physician ordered medication, [REDACTED]; not made available to resident.</p>	<p>Resident #1 has [REDACTED], however, I removed it from [REDACTED] medicine box because it has already expired. The family was informed but they did not bother to respond because [REDACTED] was not experiencing [REDACTED]. To avoid the same problem in the future, all medications ordered by the physician including PRN medications should be made available all the time. Replacement medications were made available [REDACTED].</p>	<p>4/22/16</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 no medications documented as administered on [REDACTED] medication administration record (MAR).</p>	<p>Regarding the medications documentation, I usually document after lunch when it is less busy on the day I administer the medication because mornings are quite busy. To avoid the same problem in the future, I will make sure that each time I administer the medications to the residents I will make time to document right away</p>	<p>1/13/16</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 for [REDACTED] admission.</p>	<p>When Resident #1 was first admitted [REDACTED], I already had an admission assessment. When [REDACTED] was discharged from the hospital [REDACTED], I did not do a re-admission assessment because I was not aware that [REDACTED] needed another admission assessment. In the future, when I admit or readmit a resident, I need to refer to the admission checklist to avoid the same problem. Admission assessment was done [REDACTED].</p>	<p>4/22/16</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (f)(4) General rules regarding records:</p> <p>All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency.</p> <p>FINDINGS Resident #1 binder states admission date [REDACTED], (Resident was discharged from hospital [REDACTED]).</p>	<p>[REDACTED] was the first admission date of Resident #1. When I admitted [REDACTED] back from the hospital [REDACTED], I did not put the date in the binder. In the future when I admit or readmit a resident, I will make sure to refer to the Admission Checklist so that I do not miss anything that needs to be documented and to prevent this from happening again. The re-admission date was entered in the binder [REDACTED].</p>	<p>4/22/16</p>

Licensee's/Administrator's Signature: *Tessie*

Print Name: TESSIE A CALLO

Date: 3/24/16

Licensee's/Administrator's Signature: *Tessie*

Print Name: TESSIE A. CALLO

Date: 4/27/16