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STATE OF HAWAII
DOH-OHCA

Office of Health Care Assurance

**State Licensing Section**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

| **Facility's Name: Family Ties** | **CHAPTER 100.1** |
|---|---|
| **Address:**<br>**1103-A Kahauiki Place, Honolulu, Hawaii 96819** | **Inspection Date: March 29, 2016 Annual** |

| | **Rules (Criteria)** | **Plan of Correction** | **Completion Date** |
|---|---|---|---|
| ☒ | §11-100.1-15 Medications. (e)<br>All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.<br><br>**FINDINGS**<br>Resident #1 – [redacted] written by care giver, and signed by the physician [redacted], reflected the wrong dosage. | In the future, I need to make sure my MAR & doctors medications list are the same. I need to double check before I leave the doctors office or before I transcribe to the new MAR.<br>I went to Dr. office & corrected the right dosage & units. [redacted] | 4/1/16 |
| | | ① as soon as I finished writing the medications I need to double check that all levels, dosages & units are written correctly before I bring the documents to the doctors office to be signed by the physician.<br>② Before I let the physician signed the documents. I also need to double check/review | 6/29/16 |

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-15 Medications. (m)<br>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.<br><br>**FINDINGS**<br>[redacted] | In the future, I need to make sure I sign all medications that are being given & sign them as soon as possible after the medications are given.<br>I double check to make sure all meds are sign correctly. | 3/29/14 |
| | [redacted] | | |
| ☒ | §11-100.1-17 Records and reports. (b)(3)<br>During residence, records shall include:<br><br>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;<br><br>**FINDINGS**<br>Resident #1 – Progress notes did not include observations of resident's tolerance to [redacted] and the change in order to [redacted] | In the future, I need to make sure to document in the progress notes in a monthly basis or as often as appropriate for any new changes or treatment such as my own observation regarding their tolerance or response whether good or bad. | 4/11/14 |
| | | I need to read the doctors orders & all instruction before I leave the doctors office to make sure all changes/orders are being carried out. I will document right away to the progress notes my direct observation of the residents tolerance like for instance ensure that the residents finish/consumed all without any problem.<br>I will make a followup documentation or as often as appropriate what I have observed after consuming their supplement to monitor their weight to make sure no sudden changes losing/gaining weight within a couple days/months. | 7/18/14 |
| ☒ | §11-100.1-17 Records and reports. (b)(4)<br>During residence, records shall include:<br><br>Entries describing treatments and services rendered;<br><br>**FINDINGS**<br>Resident #1 – The "Risk for Skin Impairment" service plan intervention: [redacted] however, no documentation that the intervention is carried out. | In the future, I need to make sure to read the treatment plan as often as appropriate to make sure all interventions are being carried out & documented on the MAR. Documentation has been initialed [redacted] | 4/1/14 |

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-17 Records and reports. (f)(1)<br>General rules regarding records:<br><br>All entries in the resident's record shall be written in black ink, or typewritten, shall be legible, dated, and signed by the individual making the entry; | In the future I need to make sure to use only black ink in all my records | 4/11/16 |
| | **FINDINGS**<br>Resident #1 -- Purple marker used on the [redacted] medication record. | 7 I put a reminder sign in residents records in front of my MAR to use black ink only | 6/29/16 |
| ☒ | §11-100.1-23 Physical environment. (h)(3)<br>The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.<br><br>All Type I ARCHs shall comply with applicable state laws and rules relating to sanitation, health, infection control and environmental safety;<br><br>**FINDINGS**<br>Improper sanitizing of dishes. Cups were not submerged in the sanitizing solution until corrected. | ① I will read the policy as often as appropriate for sanitizing dishes properly.<br>② I will hang the policy in front of the sink to constantly remind me for proper sanitation.<br>③ I will make sure concentrated bleach & regular bleach is always available ~~within reach~~ @ all times & bucket that can accommodate 1 to 3 gallon of water. | 6/29/16 |

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-88 Case management qualifications and services. (c)(4)<br>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:<br><br>Update the care plan as changes occur in the expanded ARCH resident care needs, services and/or interventions;<br><br>**FINDINGS**<br>The "ADL Decline" Problems and Goals service plan does not reflect that the resident requires the [redacted]. | 1 In the future I need to make sure all care plan is updated.<br><br>1 my case manager added the use of wheelchair for locomotion & mobility in a regular basis in the service plan. [redacted] | |
| | | I will put a sign/tag in my progress notes that says document your observation. | |
| | | I need to read twice or more all the the identified problems or goals on the "ADL Decline" to make sure I will not miss any problems or necessary informations needed by the resident. I will communicate to my case manager all the problems identified & to make sure there is a care plan of each problem. Before the leave I will double check & read her notes that all problem identified are being provided a care plan.<br>1 I need to observed the resident identified problem to make sure that care plan is relevant to the problem identified. | 7/18/14 |

Licensee's/Administrator's Signature: [signature]

Print Name: Mary Ann Bali

Date: 4/13/14

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Licensee's/Administrator's Signature: [signature]

Print Name: Mary Ann Bali

Date: 7/1/14

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Licensee's/Administrator's Signature: [signature]

Print Name: Mary-Ann Bali

Date: 7/19/14