Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Furukawa Residential Retreat	**CHAPTER 100.1**
Address: **47-008 Okana Place, Kaneohe, Hawaii 96744**	**Inspection Date: May 14, 2015 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. **FINDINGS** Substitute care givers #1, #2, #3, #4, #5, #6 No documentation of training to make medications available to residents.	PREPARE DOCUMENTATION OF TRAINING TO MAKE MEDICATIONS AVAILABLE TO RESIDENTS FOR SUBSTITUTE CARE GIVERS #1, #2, #3, #4, #5, #6	11/24/2015
		SEE ATTACHED	11/24/15

§11-100.1-9(e)(4): On 5/14/15 documentation of the substitute care givers' training to make medications and supplements available to residents was made available for the inspector. The PCG was informed that the form and/or contents were/was not acceptable. Please note the documentation for this training was not noted on a form provided by the DOH.

While the notation for the substitute care givers' training to make medications and supplements available to residents was not accepted by the inspector, as told to the PCG on 5/14/15, the training had taken place, hence the documentation. As indicated on the STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION on 11/24/15 new documentation regarding substitute care givers' training to make medications and supplements available to residents was prepared using the form provided by the DOH. As previous training had been provided to the substitute care givers, the past information was transferred on to the new DOH form. Additional substitute care givers' training was provided on 11/24/15. To further establish the substitute care givers' understanding of the proper protocol and documentation related to medications and supplements for the residents another series of training was provided in the form of an individual session with each substitute care giver beginning 1/16/16.
The substitute care givers' training included the following:

1) Maintain a current Physician Order for all medications and supplements for each resident.
2) Verify all medications and supplements are made available for the resident and the information noted on each medication and supplement label is consistent with the Physician's orders.
3) Enter all medications and supplements as noted on the Physician Order on to the resident's Medication Flow Sheet. Enter all medications and supplements provided or discontinued for the resident.
4) Any changes to the residents' Physician Orders, namely medications and supplements, must be noted on the residents' Identifying/Emergency Information form.
5) Any unusual response to a medication is to be documented on a Progress Note as a stand alone Progress Note as soon as it is safe to document the response.

The current method is to monitor the compliance with the proper medication and supplement protocol to include documentation as stated, continue substitute care givers' training as needed, and with each newly hired substitute care giver. PCG is to document training with each new substitute care giver on DOH form.

☒	§11-100.1-9 Personnel, staffing and family requirements. (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall: Be currently certified in cardiopulmonary resuscitation; **FINDINGS** Substitute care giver #4 No current CPR certification.	PROVIDE CPR CERTIFICATION FOR CAREGIVER #4	5/22/2015 HARD COPY OBTAINED	

§11-100.1-9(f)(1): [redacted]
The current method is to monitor the compliance with current certifications for each care giver.

For further clarification, "monitor" within our record keeping system means we have created a chart which names each staff member, their required clearances and certifications, and the expiration date of each clearance or certification. Each staff member is instructed to renew each clearance and certification BEFORE the date of expiration and provide of a copy of the clearance and/or certification to be filed in our Care Home folder. Each individual is tasked with checking when their documentation is due and the entire staff and Licensee monitors the team's compliance as well.

☒	§11-100.1-12 Emergency care of residents and disaster preparedness. (a)(3) The licensee shall maintain written procedures to follow in an emergency which shall include provisions for the following: Response to disasters which would include evacuation, emergency shelters, and food supply, and as directed by the Civil Defense. **FINDINGS** Disaster plan does not list specific addresses of shelters or evacuation points. Disaster plan lists multiple locations but does not list in which order each location would be attempted.	PROVIDE DISASTER PLAN WITH SPECIFIC ADDRESSES OF SHELTERS OR EVACUATION POINTS AND INCLUDE ORDER EACH LOCATION IN SHOULD BE ATTEMPTED	11/24/2015	

§11-100.1-12(a)(3): The Disaster Plan includes specific addresses of shelters, each location's specific evacuation point, and the order each location would be attempted. This change to the previous Disaster Plan was added 11/24/15. Each resident was notified of this addendum to the Disaster Plan; once all questions or concerns were answered each resident signed the Disaster Plan addendum. A new Disaster Plan was constructed to include specific addresses of shelters, each location's specific evacuation point, and the order each location would be attempted. This revised Disaster Plan has replaced the previous edition and is provided in its entirety to all new residents. Please find the enclosed current Disaster Plan.

☒	§11-100.1-14 Food sanitation. (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies. **FINDINGS** Laundry detergent unsecured in laundry area.	PROPERLY LABEL LAUNDRY DETERGENT AND PUT IN SECURE LOCKED CABINET	11/24/2015

§11-100.1-14(f): The laundry detergent was relocated into a locked cabinet located beneath the kitchen sink on 11/24/15. The plan is to keep the laundry detergent secured in this locked location.

The laundry detergent is stored in a locked cabinet as described. Our procedure is to dispense/obtain an amount of detergent needed to wash one load of laundry directly from the laundry detergent container while keeping the laundry detergent container within the cabinet. Then relock the cabinet and proceed with washing the laundry. Through this procedure, the laundry detergent is insight of the staff member, stored within a locked cabinet, and is removed from the locked cabinet only to be replaced.

☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 [redacted] no physician order.	HAVE PHYSICIAN ORDER FOR [redacted] FOR RESIDENT #1	5/14/15

§11-100.1-15(e): On 11/24/15 the following plan was implemented with all residents' medications, supplements, and related documentation:

1) Maintain a current Physician Order for all medications and supplements for each resident.
2) Verify all medications and supplements are made available for the resident and the information noted on each medication and supplement label is consistent with the Physician's orders.
3) Enter all medications and supplements as noted on the Physician Order on to the resident's Medication Flow Sheet. Enter all medications and supplements provided or discontinued for the resident.
4) Any changes to the residents' Physician Orders, namely medications and supplements, must be noted on the residents' Identifying/Emergency Information form.
5) Any unusual response to a medication is to be documented on a Progress Note as a stand alone Progress Note as soon as it is safe to document the response.

Any missing documentation identified during the 5/14/15 inspection was located and placed in the appropriate resident folder.

☒	§11-100.1-17 Records and reports. (a)(3) 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: Documentation of date of referral and admission, referral agency with address and telephone number, place or source from which admitted, physician, APRN, dentist, ophthalmologist, optometrist, psychiatrist, and all other medical or social service professionals who are currently treating the resident, next of kin, legal guardian, surrogate or other legally responsible agency; **FINDINGS** Resident #1 readmitted but no documentation reflecting the actual date. [redacted]	MAKE SURE TO DOCUMENT DATE OF REFERRAL AND ADMISSION, REFFAL AGENCY WITH ADDRESS AND TELEPHONE NUMBER, PLACE OR SOURCE FROM WHICH ADMITTED, PHYSICIAN, APRN, DENTIST, OPHTHAMOLOGIST OPTOMEPRIST, PYSCHIATRIST, AND ALL OTHER MEDICAL OR SOCIAL SERVICE PROFF. WHO ARE CURRENTLY TREATING RESIDENT, LEGAL GUARDIAN OR LEGALLY RESPONSIBLE AGENCY	11/24/2015

§11-100.1-17(a)(3): Any missing date identified regarding a resident's leave or discharge during the 5/14/15 inspection was identified and entered on to the Resident Register kept within the "Care Home" folder. On 11/24/15 a new plan was implemented regarding all residents' discharges and/or readmissions to immediately or as soon as reasonable without compromising the safety of any resident or staff member document either or both scenarios on to the Resident Register kept within the "Care Home" folder.

☒	§11-100.1-17 Records and reports. (a)(8) 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: A current inventory of money and valuables. **FINDINGS** Resident #1 No initial or ongoing inventory of money and valuables.	MAKE SURE TO HAVE INITIAL AND ON GOING INVENTORY OF MONEY AND VALUABLES FOR RESIDENT ON ADMISSION READMISSION, OR TRANSFER OF A RESIDENT	11/24/2015

§11-100.1-17(a)(8): Resident #1's Resident's Clothing form and Resident's Valuables form were located and placed in [redacted] resident folder. Following the inspection and for sake of providing accurate and current information on the Resident's Clothing form and Resident's Valuables form a complete inventory was taken for each current resident. From 11/24/15 forward all residents' belongings have been and will continue to be documented on to the Resident's Clothing form and/or Resident's Valuables form. New Resident's Clothing form and Resident's Valuables form are filled out on the day of arrival for each and every newly admitted resident and updated as needed. Upon a resident's discharge these forms will be referenced to insure all belongings have been returned to a resident in a timely manner.

☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: 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; **FINDINGS** Resident #1 No progress notes to reflect response to PRN [redacted] for whole months [redacted]. No progress notes to reflect response to PRN [redacted] given [redacted].	MAKE SURE TO RECORD PROGRESS NOTES TO REFLECT CHANGES TO RESIDENTS MEDICATION TO INCLUDE PRN WITH RESULTS/RESPONSE	11/24/2015

§11-100.1-17(b)(3): On 11/24/15 the following plan was implemented with all residents' medications, supplements, related responses and documentation:

Any unusual response to a medication is to be documented on a Progress Note as a stand alone Progress Note as soon as it is safe to document the response.

Additionally, specific to §11-100.1-17(b)(3) naming Progress notes, "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, …". From 4/28/16 forward, we will document "observations of the resident's response to medication", specifically newly introduced medications or PRN, on a stand alone Progress note. This is to say, once the new medication or PRN medication is provided to the resident, the staff member is to observe any response they deem may be related to "the resident's response to medication" or no perceptible response they deem may be related to "the resident's response to medication". This observation is to be documented on the resident's Progress note and filed as a separate stand alone Progress note in addition to the resident's monthly Progress note.

☒	§11-100.1-17 Records and reports. (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 made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary. **FINDINGS** Resident #1 No incident report to reflect the circumstances of resident's admissio[redacted].	MAKE SURE TO RECORD UNUSUAL INCIDENTS IN THE RESIDENT'S PROGRESS NOTES. KEEP PROGRESS NOTES UNDER SEPERATE COVER AND MAKE AVAILABLE TO THE DEPT. AND OTHER AUTHORIZED PERSONNEL.	11/24/2015

§11-100.1-17(c): Progress Notes shall include documentation of unusual incidents and are filed within a resident's folder. 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 made and retained by the licensee or PCG under separate cover and shall be made available to the department and other authorized personnel.

"...step-by-step plan of how you will make sure incident reports are created..."
As needed, defined by §11-100.1-17(c), a copy of an Incident Report will be created by answering the questions and/or filling in the blanks as directed on the Incident Report. To ensure that Incident Reports are completed as required and in a timely manner, staff members have been instructed to immediately contact the Licensee upon any occurrence requiring such reporting. The Licensee will review the contents of the Incident Report with the staff member. The licensee will check all Incident Reports as they are complete and upon regularly scheduled reviews. All Incident Reports are filed under a separate cover, and ready and available for review by the department or other authorized person

☒	§11-100.1-17 Records and reports. (e) In the event of an emergency, an oral summary of the resident's condition shall be provided to the receiving facility, followed by a written transfer summary. **FINDINGS** Resident #1 Emergency information sheet does not reflect current medications [redacted] but does reflect discontinued medication [redacted].	MAKE SURE ALL RESIDENTS' EMERGENCY INFORMATION SHEET REFLECTS ALL CURRENT MEDICATIONS	11/24/2015

§11-100.1-17(e): On 11/24/15 the following plan was implemented with all residents' medications, supplements, related documentation:

Any changes to the residents' Physician Orders, namely medications and supplements, must be noted on the residents' Identifying/Emergency Information form.

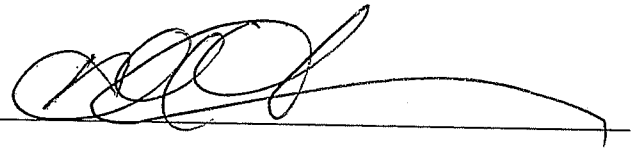
Medication and supplement changes made by the resident's physician and reflected on the resident's Physician Order are to be updated on the resident's Identifying/Emergency Information form as soon as possible. Generally, once the order has been received by the staff member changes are to be immediately documented on to the Identifying/Emergency Information form provided that taking such time does not jeopardize the safety or well-being of any resident or staff member. Meaning, as soon as possible and reasonable this documentation will be updated.

☒	§11-100.1-17 Records and reports. (f)(4) General rules regarding records: All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency. **FINDINGS** Resident #1 Physician orders, progress notes, older than [redacted] not available for review.	MAKE SURE ALL RECORDS ARE MADE READILY AVAILABLE FOR THE DEPARTMENT AND OTHER AUTHORIZED PERSONNEL.	11/24/2015

§11-100.1-17(f)(4): Resident records are retained on the premises and will be made available to the department and other authorized personnel.

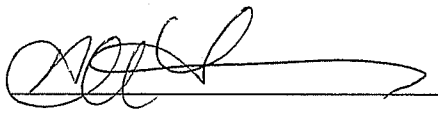
☒	§11-100.1-17 Records and reports. (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** Resident #1 Readmission not reflected in permanent general register.	MAKE SURE TO RECORD AND MAINTAIN ALL ADMISSIONS AND DISCHARGES OF RESIDENTS IN A PERMANENT GENERAL REGISTER	11/24/2015	

§11-100.1-17(h)(1): Any missing activity identified regarding a resident's leave or discharge during the 5/14/15 inspection was identified and entered on to the Resident Register kept within the "Care Home" folder. On 11/24/15 a new plan was implemented regarding all residents' discharges and/or readmissions to immediately or as soon as reasonable without compromising the safety of any resident or staff member document either or both scenarios on to the Resident Register kept within the "Care Home" folder. The action of a resident's discharge or readmission will serve as the reminder that the resident's movement out of or into the home will need to be documented on the Resident Register kept within the "Care Home" folder.

Licensee/Administrator's Signature: 

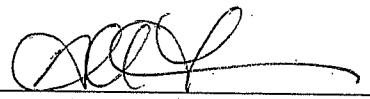
Print Name: ALLYSON FURUKAWA

Date: 11/24/15

Licensee's/Administrator's Signature: 

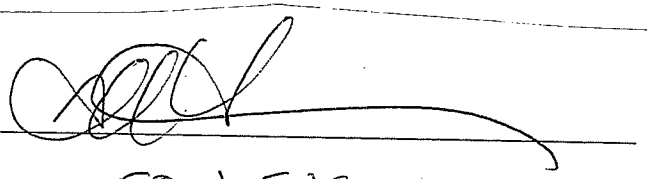
Print Name: ALLYSON FURUKAWA

Date: 3/22/16

Licensee's/Administrator's Signature: 

Print Name: ALLYSON FURUKAWA

Date: 3/22/16

Licensee's/Administrator's Signature: 

Print Name: ALLYSON FURUKAWA

Date: 4/26/16