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STATE OF HAWAII
HEALTH CARE LICENSING

Office of Health Care Assurance

**State Licensing Section**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

| **Facility's Name: Furukawa Residential Retreat, L.L.C.** | **CHAPTER 100.1** |
|---|---|
| **Address:**<br>**47-008 Okana Place, Kaneohe, Hawaii 96744** | **Inspection Date: May 13, 2016 Annual** |

| | **Rules (Criteria)** | **Plan of Correction** | **Completion Date** |
|---|---|---|---|
| ☒ | §11-100.1-8 Primary care giver qualifications. (a)(10)<br>The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall:<br><br>Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current;<br><br>**FINDINGS**<br>Primary care giver, no documentation of continuing education hours. | SEE ATTACHED | 7/7/16 |
| ☒ | §11-100.1-15 Medications. (e)<br>All medications and supplements, such as vitamins, minerals, | SEE ATTACHED | 5/16/16 |

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| | and formulas, shall be made available as ordered by a physician or APRN.<br><br>**FINDINGS**<br>[redacted] | SEE ATTACHED | 5/16/16 |
| ☒ | §11-100.1-15 Medications. (n)<br>Self administration of medication shall be permitted when it is determined to be a safe practice by the resident, family, legal guardian, surrogate or case manager and primary care giver and authorized by the physician or APRN. Written procedures shall be available for storage, monitoring and documentation.<br><br>**FINDINGS**<br>[redacted] no physician order for self-administration of medication. [redacted] | SEE ATTACHED | 5/16/16 |
| ☒ | §11-100.1-17 Records and reports. (a)(4)<br>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:<br><br>A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; | SEE ATTACHED | 5/16/16 |

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| | **FINDINGS**<br>[redacted] No documentation of two-step tuberculosis clearance prior to admission. | SEE ATTACHED | 5/16/16 |
| ☒ | §11-100.1-17 Records and reports. (b)(5)<br>During residence, records shall include:<br><br>Entries detailing all medications administered or made available;<br><br>**FINDINGS**<br>[redacted] | SEE ATTACHED | 5/16/16 |

Licensee's/Administrator's Signature [redacted]

Print Name: [redacted]

Date: 7/7/16

§11-100.1-8 Primary care giver qualifications. (a)(10)
PCG had taken a Nutrition Update and Orientation class provided by the DOH [redacted]. This documentation was not provided to the Consultant on [redacted]. The aforementioned certificate copy is now in PCG's folder at the care home. PCG to keep [redacted] continuing education records on premises and available for Consultant. Licensee to monitor the records of the PCG on a monthly basis, insuring all records are kept at the care home and available for the Consultant upon request. In the future, if any required records pertaining to the PCG are not readily available, the Licensee will notify the PCG and confirm the correction.

§11-100.1-15 Medications. (e)
Following the inspection the Licensee reviewed the Medication Flow Sheet and spoke with a staff member regarding their notation with Irbesartan. It was learned that there was a confusing notation made; the staff member's initials indicated the blood pressure was taken but the medication held as prescribed may not have been clearly indicated. Additionally, as identified by the Consultant, a separate notation challenge appears yet again with the same medication. In summary, there was some inconsistencies amongst the staff's notation regarding the blood pressure reading, what followed, by whom written within one square on the Medication Flow Sheet. Fortunately, all staff members correctly acknowledged how to follow the Physician Order. The staff's method of entry varied, yet their understanding of what to do and when was consistent.

[redacted] the Licensee informed all staff members of the incorrect notations identified by the Consultant. The Licensee reviewed the correct procedure for making the mediations/supplements available to the residents and the proper notation to follow. Additionally, there was a memo posted on the medication cabinet describing the procedure for notations made on the Medication Flow Sheet with an initialed acknowledgement from each staff member. The PCG and Licensee have since monitored the notations on the Medication Flow Sheet on a daily basis and have provided feedback to the staff members. To date, reminders to the staff regarding their notation have proven successful. The PCG and Licensee plan to continue the monitoring with planned in-services to serve as reminders scheduled on a monthly basis or sooner if indicated. Consequences for any staff member not following the protocol will be handled on a case-by-case basis ranging from a written notice identifying the incorrect entry followed up with a conversation with the PCG to insure the staff member's understanding and compliance, to terminating the staff member due to noncompliance.

§11-100.1-15 Medications. (n)
A Physician Order indicating "self-administered" medication for [redacted] was not made available for the Consultant. Enclosed are two Physician Orders with "self-administered" indicated as directed by [redacted] physician. Additionally, there are no parameters or hold orders [redacted] indicated on the Physician Orders.

[redacted]

. Therefore, following the inspection the Licensee contacted physician's office, Registered Nurse, and family member and discussed the concern. A case manager was secured and the Licensee supported the family with locating an alternate care location.

We maintained frequent contact with the Registered Nurse that was originally brought in . Future care and related documentation will not be a part of our plan .

§11-100.1-17 Records and reports. (a)(4)
The TB clearance mistakenly indicated a date that had not yet occurred; . Please see the enclosed TB clearance indicating the correct date the test and reading was performed. To prevent this type of error from reoccurring, the PCG is to carefully inspect residents' documents PRIOR to accepting them from the family or physician. If an error occurs the PCG shall remedy the situation with the responsible party as soon as possible. The PCG and/or Licensee shall review all resident and care home documents on a monthly basis to confirm all contents including dates are correct. Furthermore, posted are residents and staff names with the expiration dates of various clearances. The entire team has been instructed to monitor the expiration of their documents as well as remind others of the same. Consequences for any staff member not following the protocol will be handled on a case-by-case basis ranging from a written notice identifying the expired document followed up with a conversation with the PCG to insure the staff member's understanding and compliance, to terminating the staff member due to repeated noncompliance.

§11-100.1-17 Records and reports. (b)(5)
the Licensee informed all staff members of the incorrect notations identified by the Consultant. The Licensee reviewed the correct procedure for making the mediations/supplements available to the residents and the proper notation to follow. Additionally, there was a memo posted on the medication cabinet describing the procedure for notations made on the Medication Flow Sheet with an initialed acknowledgement from each staff member. The PCG and Licensee have since monitored the notations on the Medication Flow Sheet on a daily basis and have provided feedback to the staff members. To date, reminders to the staff regarding their notation have proven successful. The PCG and Licensee plan to continue the monitoring with planned in-services to serve as reminders scheduled on a monthly basis or sooner if indicated. Consequences for any staff member not following the protocol will be handled on a case-by-case basis ranging from a written notice identifying the incorrect entry followed up with a conversation with the PCG to insure the staff member's understanding and compliance, to terminating the staff member due to noncompliance.