Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Hale Kupuna	**CHAPTER 100.1**
Address: **1783 Piikea Street, Honolulu, Hawaii 96818**	**Inspection Date: October 2, 2015 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-12 Emergency care of residents and disaster preparedness. (b) The licensee shall maintain a first aid kit for emergency use for each Type I ARCH. **FINDINGS** First aid kit had multiple packets of cream and alcohol pads with expired dates.	First Aid kit immediately updated; it is now checked monthly & a sheet maintained to remind us to do this, similar to our check list for smoke detectors (all staff made familiar w/ this)	10/3/15 – ⊕ ongoing
☒	§11-100.1-14 Food sanitation. (c) Refrigerators shall be equipped with an appropriate thermometer and temperature shall be maintained at 45°F or lower. **FINDINGS** Refrigerator had no thermometer.	thermometer purchased; sheet/list maintained as in correction above (ost listed) (All staff made familiar w/ this)	10/3/15 – ongoing

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-15 Medications. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. **FINDINGS** 1. Multiple vials of [redacted] in resident bedrooms. 2. Resident #1 over the counter medications [redacted]. All expiration dates crossed out and marked refill.	2.) All (outdated) old OTC. med bottles disposed of. Only currently purchased bottles used. Expiration dates checked monthly by nsc. since inspection 1.) [redacted] removed from room & Kept in med cabinet, dispensed only at ordered times by staff. Check daily on med sheet & locating in med cabinet	10/2/15 10/2/15
		1: All [redacted] are in med cabinet now & only taken out to use at prescribed time & returned to cabinets 2: All old containers discarded & OTC. meds are ONLY in container in which they were purchased. Nothing outdated in Med. Cabinet (Res #1 & all others) (All staff aware / following these practices)	10/3/15 & ongoing

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§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] medication not available.	[redacted] purchased; placed in pt's medicine Box. Every week Med orders checked against med sheets & Stock on hand - re-ordered as needed Rel. WKly check. by me (CHO)	10/3/15
☒	§11-100.1-15 Medications. (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. **FINDINGS** 1. Resident #1 progress note [redacted] reflects [redacted] no entry on medication administration record (MAR). 2. Resident #1 physician order [redacted] reads, [redacted] No entry on MAR indicating that medication was given. 3. Resident #1 physician orders [redacted] MAR does not reflect if medication was given for either date.	(Res #1) All MARS corrected; teaching done c all staff re. importance of documentation this is checked weekly by me. CH.O. 1) All Med errors corrected. We now immediately document every med given at time of dispensing it. All charting checked every week by CHO (me) to make sure nothing has been omitted. 2) Past med errors corrected; all meds documented on dispensing. CHO does doublecheck on this weekly (initiated after inspection) 3) Past med errors corrected; all meds now documented on dispensing. CHO (me) does doublecheck on this weekly (initiated after inspection)	10/3/15 & ongoing 10/3/15 10/3/15 10/3/15

☒	§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** 1. Resident #1 [redacted] monthly summary missing. 2. White out used to make correction in chart.	Copy of Progress Note from chart; was present during inspection - I don't remember this issue during inspection or I would've looked @ inspectors. White out removed; all instructed never allowed - [redacted] No change in Resident = less frequent charting	10/3/15 & ongoing
		2) White out disposed of; all staff instructed to never use it. I check this on a weekly basis since inspection. Old sheets done over (ones w/ white out)	10/2/15
☒	§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 data sheet incomplete, medication not listed on back of form. Medications listed on front of form not current medications.	All meds now listed (currently used) on emergency data sheet. These are checked monthly against M.D. orders MAR & compared to Emergency data sheet by me. CMO (since inspection)	10/3/15
☒	§11-100.1-23 Physical environment. (o)(3)(B) Bedrooms: Bedroom furnishings: Each bed shall be supplied with a comfortable mattress cover, a pillow, pliable plastic pillow protector, pillow case, and an upper and lower sheet. A sheet blanket may be substituted for the top sheet when requested by the resident;	I instructed staff that we will continue to use pillows only after writing patient's name on it & they are to be disposed of if patient not here. We are now using sheet blankets for clients that do not want top sheets. This is checked daily by me/CMO	10/3/15

	Rules (Criteria)	Plan of Correction	Completion Date
	followed by a written transfer summary. **FINDINGS** Resident #1 emergency data sheet incomplete, medication not listed on back of form. Medications listed on front of form not current medications.	Emergency data sheet corrected. All clients data sheets checked & correct.	10/3/16 & ongoing
☒	§11-100.1-23 Physical environment. (o)(3)(B) Bedrooms: Bedroom furnishings: Each bed shall be supplied with a comfortable mattress cover, a pillow, pliable plastic pillow protector, pillow case, and an upper and lower sheet. A sheet blanket may be substituted for the top sheet when requested by the resident; **FINDINGS** No plastic covers on residents' pillows, and names not written on pillows.	Residents that prefer No Plastic may have names written on pillows.	10/3/16 & ongoing

Licensee's/Administrator's Signature: Barbara Weber RN/CBA

Print Name: Barbara Weber

Date: 2/20/16

Licensee's/Administrator's Signature: Barbara Weber

Print Name: Barbara Weber

Date: 3/22/16