

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Hokulaki Elder Care, LLC	CHAPTER 100.1
Address: 45-526 Nakuluai Street, Kaneohe, Hawaii 96744	Inspection Date: February 3, 2016 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p>FINDINGS Substitute Care Giver #1 No documentation of training by primary care giver to make medications available and document such action.</p>	SEE ATTACHED	
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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</p>		

	Rules (Criteria)	Plan of Correction	Completion Date
	<p>storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms.</p> <p>FINDINGS Resident #1 [REDACTED] No proper label detailing for whom the medication is prescribed to, medication schedule, medication side effects, and medication precautions.</p>	SEE ATTACHED	
☒	<p>§11-100.1-17 <u>Records and reports.</u> (a) 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>FINDINGS Resident #1 No medication administration record [REDACTED]. No progress notes [REDACTED]. Per primary care giver, computer file corrupted.</p>	SEE ATTACHED	
☒	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>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;</p> <p>FINDINGS Resident #1 No progress notes [REDACTED]. Per primary care giver, computer file corrupted.</p>		

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(5) During residence, records shall include:</p> <p>Entries detailing all medications administered or made available;</p> <p><u>FINDINGS</u> Resident #1 No medication administration record [REDACTED]. Per primary care giver, computer file corrupted.</p>	<p>SEE ATTACHED</p>	
<input checked="" type="checkbox"/>	<p>§11-100.1-21 <u>Residents' and primary care givers' rights and responsibilities.</u> (a)(1)(C) Residents' rights and responsibilities:</p> <p>Written policies regarding the rights and responsibilities of residents during the stay in the Type I ARCH shall be established and a copy shall be provided to the resident and the resident's family, legal guardian, surrogate, sponsoring agency or representative payee, and to the public upon request. The Type I ARCH policies and procedures shall provide that each individual admitted shall:</p> <p>Be fully informed orally and in writing, prior to or at the time of admission, and during stay, of services available in or through the Type I ARCH and of related charges, including any charges for services not covered by the Type I ARCH's basic per diem rate;</p> <p><u>FINDINGS</u> Resident #1 No general operating policy detailing specific charges for services attached to signed agreement.</p>	<p>SEE ATTACHED</p>	



PLAN OF CORRECTION

Facility's Name: Hokulaki Elder Care, LLC

Date of Inspection: February 3, 2016 (Annual)

11-100.1-9 (a)

Substitute Caregiver #1 was trained on all aspects of medication [REDACTED] but forgot to sign the inservice roster or sign-in sheet after receiving the training at that time. Substitute Caregiver #1 signed the "Training Sign-In Sheet" after going through the 'Medication Policies and Procedures' right after the annual inspection [REDACTED]

To avoid the same mistake in the future, the sign-in sheet will be checked twice by PCG or a designated staff to make sure that every attendee of the training or inservice has signed and dated the sign-in sheet form. The PCG and the designated staff will also announce after the training that all attendees will "sign and date training sign-in sheet."

Completion Date: February 3, 2016

11-100.1-15 (a) Medications

Resident #1 [REDACTED] sample bottle was immediately and properly labeled after the inspection which included the Resident #1's name; date when it was prescribed; name of the medication and dosage per tablet; instructions of how much dosage to give; its route of administration and the name of the doctor who prescribed the medication.

In the future, to avoid the same mistake, if the prescribing physician gives a bottle of sample medication to the resident, the sample bottle will be labeled immediately and properly once the resident and PCG or substitute caregiver arrives at the care home. The label will include the name of the resident, the date the medication was prescribed; dosage, instructions on how to give and rout, the name of the prescribing physician and will also note the expiration date.

Completion Date: February 3, 2016

11-100.1-17 (a)(b)(3)(5)

Resident #1 files for Medication Administration Records and Progress Notes were inadvertently deleted when the computer automatically changed from Windows 7 to Windows 10. For some reason it automatically changed even without the PCG wanting to convert the present program into the new program yet. The files have not been saved to an external saving device yet as that's what the intention was (to complete all forms and printed) after the chart was completely done and ready for inspection,

[REDACTED]

Page 2:**11-100.1-17 (a) (b)(3)(5) (Continuation)**

All the Medication Administration Records (MAR) were retrieved from the computer and given to the DOH Consultant but not completely initialed and signed for inspection so that they were deemed incomplete. All MARs were completed, initialed and signed after the inspection, and placed in Resident #1's medical record chart.

Some missing Progress reports were not recoverable. The salvaged ones were initialed after every entry, then placed in Resident #1's medical record chart.

In the future, all working copies will be saved to an external saving device such as USB thumb drives or 'passport' devices to avoid losing data again. Will save all the data after every paragraph written or immediately after completely filling out forms or doing narrative reports to the external saving device. PCG will use a second external saving device to save another set of data just in case the first one defaults.

Completion Date: February 4, 2016

Resident #1's POA [REDACTED] signed for all the admission paperwork which also included consents and the contract agreement and fees upon admission of said resident to the Home. PCG searched for the 'Fee Agreement' but could not find when asked about the 'Fee Agreement' during the inspection. Found the 'Fee Agreement' later filed in a different 'residents' financial file.' The contract agreement with the fee form is filed under Resident #1's file now and secured in a locked cabinet in the Care Home's office.

To prevent from making the same mistake in the future, PCG will check and make sure that every resident's file will be checked immediately right after the Resident's family or POA sign the contract agreement and every 6 months thereafter to make sure that all Resident's contracts and fee agreements are in their proper files.

Completion Date: February 18, 2016

[REDACTED]