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Office of Health Care Assurance

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State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OF HAWAII

NSR-OHCA LICENSING

Facility's Name: Huapala Senior Care D, LLC	CHAPTER 100.1
Address: 2649 D Huapala Street, Honolulu, Hawaii 96822	Inspection Date: May 5 & 6, 2016 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p>FINDINGS</p> <p>[REDACTED]</p> <p>Resident #2 – Telephone order taken [REDACTED] did not specify the frequency.</p> <p>[REDACTED]</p>	<p>MSC = Manoa Senior Care</p> <p>The Vitamin [REDACTED] entry on the [REDACTED] medication record was rewritten to reflect the correct strength [REDACTED]. DON reinforced with both Nurses in the home: 1) New orders need to be transcribed to the medication record accurately; 2) the 3 checks during medication pass, as listed in the MSC medication administration policy, should always be done. That allows for any transcription errors to be caught when the label on the medication bottle is checked against the medication record.</p> <p>The [REDACTED] order was clarified with the physician to include the frequency. DON reviewed with both nurses in the home that all medication orders should include the name and strength of the medication, dosage, route, and frequency.</p> <p>A green "directions changed" sticker was placed on the [REDACTED] medication label. DON reviewed with the both Nurses in home following medication administration guideline:</p> <ul style="list-style-type: none"> • When a new medication order is received from the Doctor/Nurse Practitioner, and requires the instructions on the original medication container to be changed, a green "Directions ▲ (changed)" sticker should be placed over the instructions on the original label. 	
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals,</p>	<p>For all 3 findings, the DON/ADON will do periodic random medication record and medication storage cabinet audits to ensure compliance.</p>	

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	Rules (Criteria)	Plan of Correction	Completion Date
	<p>and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initiated by the care giver.</p> <p>FINDINGS [REDACTED]</p>	<p>DON reinforced with both nurses in the home:</p> <ol style="list-style-type: none"> 1) New orders need to be transcribed to the medication record accurately; 2) The 3 checks during medication pass, as listed in the MSC medication administration policy, should always be done. That allows for any transcription errors to be caught when the label on the medication bottle is checked against the medication record. <p>The DON/ADON will do periodic random audits to ensure compliance.</p>	<p>5/4/16 ~</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p>FINDINGS [REDACTED]</p>	<p>The current procedure for the [REDACTED] MD/NP is to leave an "after visit summary" after he/she makes a visit to the home. The after visit summary is a short synopsis of the visit. The full note was obtained from the MD's office which reflected that a physical was performed [REDACTED]</p> <p>Both nurses in the home were reminded that when a resident's physical is due, the full note needs to be obtained from the physician. The DON/ADON will do periodic random audits to ensure compliance.</p>	<p>5/4/16 ~</p>
<input checked="" type="checkbox"/>	<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 – Progress notes did not specify the location/source of [REDACTED] received pain</p>	<p>This finding was reviewed with both Nurses in the home. During the monthly House meeting, [REDACTED] it was reviewed with the primary nurse aide staff in the home that all authorized prn medications given should be documented in the MSC caregiver progress notes. The documentation should include the medication given, dosage, time given, specific reason for the medication being given, and name of nurse who authorized the prn. The nurses in the home will also remind any float nurse aides of the above when they work in the home and are authorized by the Nurse to give a prn. The DON/ADON will do periodic random chart audits to ensure compliance.</p>	<p>5/4/16 ~</p>

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	medication [REDACTED]		
☒	<p>§11-100.1-17 <u>Records and reports.</u> (b)(4) During residence, records shall include:</p> <p>Entries describing treatments and services rendered;</p> <p>FINDINGS Resident #1 – No documentation that [REDACTED] were provided as ordered [REDACTED].</p>	<p>The order for [REDACTED] was clarified on and profiled on the medication record. DON explained to the nurses in the home that any order for [REDACTED] should be documented on the MAR and signed off to reflect that it was provided. The DON/ADON make regular rounds in the home and receives updates on the residents. During report, when the nurse informs the DON/ADON of a resident receiving an order for [REDACTED], the DON/ADON will remind the nurse to transcribe the order to the MAR. The DON/ADON will do periodic random audits to ensure compliance.</p>	5/9/16 r
☒	<p>§11-100.1-17 <u>Records and reports.</u> (f)(1) General rules regarding records:</p> <p>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;</p> <p>FINDINGS Resident #1 – Progress notes were not signed by the individual making the entry [REDACTED].</p>	<p>The Nurse who documented [REDACTED] signed it [REDACTED] after the finding was communicated. DON reviewed with both nurses in the home that all charting entries into the MSC caregiver progress notes should be signed by the person documenting using their full signature and title. The DON/ADON will do periodic random audits to ensure compliance.</p>	5/9/16 r
☒	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(2) 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:</p> <p>Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the</p>		

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	<p>expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident;</p> <p>FINDINGS Resident #1 – Care plan did not reflect [REDACTED]</p> <p>Resident #1 – No care plan for resident identified with [REDACTED] risk.</p>	<p>The case manager faxed the revised care plan to the home [REDACTED] which reflected [REDACTED] precautions. DON spoke to the case manager and informed [REDACTED] that care plans need to be individualized and thorough.</p> <p>Both nurses in the home were reminded that the initial care plan should always be reviewed once received. The case manager should be contacted for any missing information so the care plan can be revised timely. The case manager and MSC nurse should also sit review the care plan together when the case manager visits to ensure that it is updated, accurate, and new problems are care planned.</p>	<p>5/4/16 M</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (h) 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.</p> <p>FINDINGS Bedroom #4 – Shower room ceiling light is not working.</p>	<p>The shower room ceiling light will be fixed within 2 weeks. The Director of Facilities Management will do periodic checks in the home to identify any maintenance issues that need to be fixed.</p>	<p>6/3/16 M</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (r) Facilities shall be maintained in accordance with provisions of state and local zoning, building, fire safety and health codes.</p> <p>FINDINGS</p>		

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	Three (3) entrance double doors and the right back exit double doors have gaps in between the two (2) opposing doors.	The gaps between the doors will be fixed within 2 weeks. The Director of Facilities Management will do periodic checks in the home to identify any maintenance issues that need to be fixed.	6/3/16 w

