Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: ORI – Unit #10 (DDDH)	**CHAPTER 89**
Address: **64-1498 Kamehameha Highway, Wahiawa, Hawaii 96786**	**Inspection Date: July 7, 2015 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-89-14 Resident health and safety standards. (e)(2) Medications: Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container. **FINDINGS** Resident #1's [redacted] was kept unsecured in the refrigerator.	The case manager was advised to check all medications prescribed from the physician to ensure that all medication are all properly locked in the refrigerator. ORI purchased a locked container that can be kept in the refrigerator to use for medication safety.	7/08/15
		It was reminded to the caregiver, that medication with special directions is to be refrigerated and locked in a special container. The case manager was instructed to monitor container periodically to check if medication is stored safely and locked.	10/27/15

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-89-14 Resident health and safety standards. (e)(5) Medications: All medications and supplements, such as vitamins, minerals, and formulas shall be made available by written physician order and shall be based upon current evaluation of the resident's condition.		
	FINDINGS [redacted]	**The Physician's order indicating the use of [redacted] was found and attached. The case manager was reminded that anytime a client goes to the doctor, make sure all physician's order must be filed in the client binder.**	**7/08/15**
		The Physician's order indicating the use of [redacted] was found and attached. The case manager was advised to file physician's orders immediately to prevent misplacement. In-service training to review the proper procedure of filing medical documents for clients will be provided and reviewed annually.	10/27/15

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-89-14 Resident health and safety standards. (e)(6) Medications: **All physician orders shall be re-evaluated and signed by the physician every three months or at the next physician's visit, whichever comes first.** **FINDINGS** [redacted]	**The case manager was advised to check 90 day medication update for any discrepancies especially the dosage and instructions before letting the doctor sign.**	**7/08/15**
		The case manager was advised to file the physician's orders immediately to prevent misplacement. In-service training to review the proper procedure of filing medical documents for clients was given. In addition, clients files will be inspected periodically for quality assurance.	10/27/15
		The case manager and the caregivers received retraining from the nurse in proper procedures for medication administration and proper documentation of all medication orders from the physician and the labels of the medication when received from the pharmacy. The nurse further reinforced the importance of administering, checking and documenting the correct dosage of medication. The case manager was reminded that [redacted] will be responsible for listing the medications for the medication updates, reviewing the update and to correct any discrepancies noted, prior to the Doctor's signature. In-service training will continue to be provided to ensure proper understating on the importance of proper notation and recording of all medications, accuracy and timeliness.	11/24/15

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-89-14 Resident health and safety standards. (e)(12) Medications: All medications and supplements, such as vitamins, minerals, and formulas, shall have written physician's orders and shall be labeled according to pharmaceutical practices for prescribed items. When taken by the resident, the date, time, name of drug, and dosage shall be recorded on the resident's medication record and initialed by the certified caregiver. FINDINGS [redacted]	Re-training was given and completed by the caregiver to emphasize the importance of medical records and proper initialing when medications is administered. The case manager also received a training to create data sheets that give the exact instructions of the medication 90 day update. In addition, time changes with medication distribution must be noted on Medical Log. The case manager will double check the caregiver's records upon submitting to catch any inconsistencies or discrepancies in client's medication log. The case manager and the caregiver were counseled for the failure of finding the errors in the medical logs, despite retraining. They were reminded in the importance of identifying the medication usage and to synchronize the proper medication time with the medical log. Both the caregiver and the case manager understood the reason for the citations and were warned that further errors will be documented and will result in disciplinary warnings.	7/08/15 7/08/15 10/27/15

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-89-14 Resident health and safety standards. (e)(12) Medications:	Case manager and caregivers received retraining from the nurse in proper procedure for medication administration recording of all medication including the label of medications coming from the pharmacy. The case manager was reminded in the following, - Monitor the caregiver through regular and unannounced inspections to check the medication records for proper time and endorsement when given. - Cross evaluate the physician orders, medication record sheets and pharmacy labels for constancy. - Collect the physician's orders immediately after the appointment and then update previous medication and/or adding new medication into the medication record sheets per instruction of the physician's orders. - Updating the 3-month medication sheets at the end of every 90 days. This will include the review of the corresponding medical records per client and then submitting it to physician for review and signature.	11/24/15
		Updating the 3-month medication update at the end of every 90 days. This will include the review of the corresponding medical records per client and then submitting it to physician for review and signature. Review to ensure medication update corresponds with medication log.	1/6/16 1/6/16

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-89-18 Records and reports. (b)(2) During residence, records shall be maintained by the caregiver and shall include the following information: Observations of the resident's response to medication, treatments, diet, provision of care, response to activities programs, indications of illness or injury, unusual skin problems, changes in behavior patterns, noting the date, time and actions taken, if any, which shall be recorded monthly or more often as appropriate but immediately when an incident occurs; **FINDINGS** [redacted]	**The caregiver was reminded that as needed medication must be documented in the caregiver entries or as a supplement note. In addition the caregiver was retrained to include any and all incident reports that client had during the month as well as the response of the client for the medication given to the [redacted].** **The case manager will review the submitted entries and notes in order to check for the proper response.**	7/08/15
		The caregiver received training by the RN Consultant on documenting as needed medication in the caregiver entries, or as a supplemental note. The case manager was instructed to review the submitted entries and notes in order to check for the proper response. It was further reminded to both that negligence in documenting medication effects will result in disciplinary warnings.	10/27/15
		The case manager and the caregivers received retraining from the nurse in proper procedures for medication administration and recording of all medications, including the label of medications coming from the pharmacy. The case manager was reminded, that when reviewing the caregiver entries and/or supplemental notes, cross check the medication records for the time endorsed and the physician notes for proper usage. The case manager was further reminded that this review will take place at least on a monthly basis per the submittal of the caregiver entries and/or notes. In-service training will continue to be provided to all direct care staff's to ensure proper understanding on the importance of proper notation and recording of client respond to treatment.	11/24/15

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-89-18 Records and reports. (b)(2) During residence, records shall be maintained by the caregiver and shall include the following information:	The case manager was farther reminded that this review will take place at least on a monthly basis per the submittal of the caregiver entries and/or notes. In-service training will continue to be provided to all direct care staff to ensure proper understanding on the importance of proper notation and recording of client response to treatment.	1/4/16
		The case manager was reminded, that when reviewing the Caregiver entries and/or Supplemental notes, cross check the medication records for the time endorsed and the physician notes for proper usage.	1/4/16

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-89-18 Records and reports. (b)(7) During residence, records shall be maintained by the caregiver and shall include the following information: Recording of resident's weight at least once a month, and more often when requested by a physician;		
	FINDINGS For Resident #1, weights were not recorded [redacted].	The case manager was reminded to update the weights of all clients on a monthly basis. Weigh chart was completed and attached for your review.	7/08/15
		Weight chart was completed and attached for your review. In-service training was provided to the case manager to track and update the weights of all clients on a monthly basis.	10/27/15

Licensee's/Administrator's Signature: shudson / RFok

Print Name: Susan Hudson / Rose Fok

Date: 8/04/2015

Licensee's/Administrator's Signature: [signature]

Print Name: Mrs Susanna F. Cheung

Date: 10/28/15

Licensee's/Administrator's Signature: Rose M. Fok for Susanna F. Cheung Rose M. Fok

Print Name: Susanna F. Cheung

Date: November 30, 2015

Licensee's/Administrator's Signature: [signature] / shudson

Print Name: James Horton / Susan Hudson

Date: 1/08/16