

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  12G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/15/2016
--------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------------------------	----------------------------------------------

RECEIVED

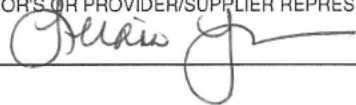
2016 MAY -6 P 2:01

STATE OF HAWAII  
DOH-CLIA DIVISION

NAME OF PROVIDER OR SUPPLIER  THE ARC IN HAWAII - 6 A	STREET ADDRESS, CITY, STATE, ZIP CODE 852 PAAHANA STREET HONOLULU, HI 96816
-------------------------------------------------------------	-----------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
9 000	INITIAL COMMENTS  A licensure survey was conducted from 4/13/16 through 4/15/16. The facility is licensed for 4 beds. The census at the time of the survey was 4.	9 000		
9 151	11-99-15(b) INFECTION CONTROL  There shall be appropriate policies and procedures written and implemented for the prevention and control of infections and the isolation of infectious residents.  This Statute is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure it provided a sanitary environment to avoid sources and transmission of infections.  Findings include: <div style="background-color: black; width: 100%; height: 40px; margin-top: 5px;"></div> <div style="background-color: black; width: 100%; height: 40px; margin-top: 5px;"></div>	9 151	9 151 11-99-15(b) INFECTION CONTROL  PLAN OF CORRECTION 1) HM reviewed proper glove use and handwashing with HW.  RN to retrain HW on infection control, emphasizing proper glove use and handwashing. RN to explain to HW that if wearing gloves, once you touch dirty hands, even to sanitize a participants hands, that those gloves are no longer clean and need to be changed.  2) RN discussed importance of handwashing with HM immediately following exit conference.  HM was trained by RN and Nurse Manager on 4/18/16 on all nursing policies and procedures, including but not limited to infection control, handwashing, and glove use.  SYSTEMIC Nurse Manager reviewed importance of handwashing with all Home Managers at monthly HM's meeting.  Nurse Manger will create a hand washing flyer to be posted in each home to remind staff to wash hands and change gloves.  QUALITY ASSURANCE Home Managers to monitor that staff are following infection control procedures in regards to handwashing and glove use.  RN to follow up with HM's on any infection control issues or concerns at monthly meetings.  At quarterly observations, RN's will monitor staff adherence to infection control procedures, handwashing, and glove use. RN will document findings in their quality assurance checklists and train or retrain staff as needed.	4/15/16  5/15/16  4/15/16  4/18/16  4/27/16  5/15/16  Daily  Monthly  Quarterly

Office of Health Care Assurance  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Exec. Director





(X6) DATE

5/4/16

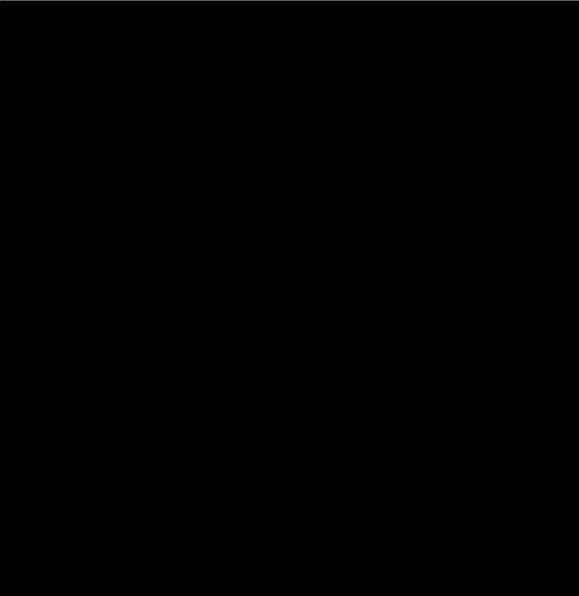
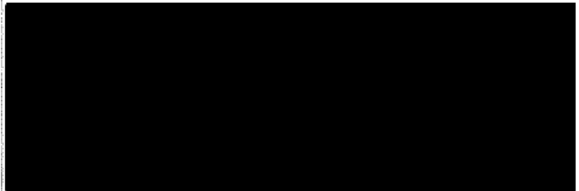


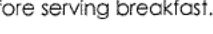

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  12G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/15/2016
--------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER  THE ARC IN HAWAII - 6 A	STREET ADDRESS, CITY, STATE, ZIP CODE 852 PAAHANA STREET HONOLULU, HI 96816
-------------------------------------------------------------	-----------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
9 151	Continued From page 1 	9 151		
9 189	11-99-22(c) PHARMACEUTICAL SERVICES  Each drug shall be rechecked and identified immediately prior to administration. This Statute is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure that all medications are administered without error for 2 of 3 clients (Clients #1 and #2) in the case sample.  Findings include: 	9 189	9 189 11-99-22(C) PHARMACEUTICAL SERVICES  1) PLAN OF CORRECTION HM was trained by RN on medication administration so that  could complete the medication pass.  HW will be retrained by RN on the Arc's medication administration policies which ensure that the dose on the medication label and the dose on the MAR are the same before administering any medication.  SYSTEMIC and QUALITY ASSURANCE All ICF HM's to complete weekly medication checks and notify RN of any dosage discrepancies between the MAR and the medication label.  RN's to complete quarterly medication reviews for each participant and ensure there are no dosage discrepancies with their medications.  Nurse Manager to ensure RN's quarterly medication reviews are completed quarterly.  2) PLAN OF CORRECTION HW will be retrained by RN on Arc's medication administration policy  in the meantime, HM has been trained to pass meds.	4/18/16  5/15/16  Weekly  Quarterly  On-going  5/15/16

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  12G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/15/2016
NAME OF PROVIDER OR SUPPLIER  THE ARC IN HAWAII - 6 A		STREET ADDRESS, CITY, STATE, ZIP CODE 852 PAAHANA STREET HONOLULU, HI 96816		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
9 189	Continued From page 2  	9 189	9 189 11-99-22(C) PHARMACEUTICAL SERVICES CONTINUED  HM purchased a dual alarm clock for the home. The alarm clock will be set  to alert staff to give client #1  medication  and wait fill the second alarm goes off  before serving breakfast.  SYSTEMIC Dual alarm clocks will be purchased for all ICF homes in which participants have specific Physician Ordered time restrictions for their medications.  QUALITY ASSURANCE HM's to monitor and observe random medication passes to ensure all clients receive medications as ordered and notify RN of any training or retraining that may be needed.  RN's to follow up with HM's at monthly meetings regarding any issues or concerns with medication administration and following Physicians Orders.  RN's to complete quarterly medication administration observations to monitor for any issues or concerns with following Physicians Orders for medications and train or retrain staff as needed.	4/19/16  5/15/16  On-going  Monthly  Quarterly