Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: The Arc in Hawaii – Lusitana C (DDDH)	**CHAPTER 89**
Address: **1660 C Lusitana Street, Honolulu, Hawaii 96813**	**Inspection Date: November 5, 2015 Annual**

	Rules (Criteria)	**Plan of Correction**	**Completion Date**
☒	§11-89-9 General staff health requirements. (a)(1) All individuals living in the facility including those who provide services directly to residents shall have documented evidence that they have had examination by a physician prior to their first contact with the residents of the home and thereafter as frequently as the department deems necessary. The examination shall be specifically oriented to rule out communicable disease and shall include tests for tuberculosis. If an initial tuberculin skin test is negative, a second tuberculin skin test shall be done after one week, but no later than three weeks after the first test. The results of the second test shall be considered the baseline test and shall be used to determine appropriate treatment follow-up. If the second test is negative, it shall be repeated once yearly thereafter unless it becomes positive. **FINDINGS** The Personnel/Household Members Information form noted that Caregiver #1 was hired and dates of the two-step TB skin tests were noted as and	Left Blank Intentionally	

	Rules (Criteria)	Plan of Correction	Completion Date
	which does not comply with the two-step TB skin test requirement. (NOTE: Please submit a copy of Caregiver #1's two-step TB skin test with your plan of correction.)	Left Blank Intentionally	
☒	§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** For Resident #1, untimely medication update for from December 31, 2014 to April 30, 2015. For Resident #1, 3-month medication update of August was not signed by the physician until October	Left Blank Intentionally	
☒	§11-89-14 Resident health and safety standards. (e)(11) Medications: Discontinued or outdated medications shall be disposed of by flushing down the toilet. **FINDINGS** For Resident #1, label on the bottle noted the expiration date as July 2015; however, the expiration date on the box was noted as June 2016.	Left Blank Intentionally	
☒	§11-89-14 Resident health and safety standards. (e)(12) Medications:	Left Blank Intentionally	

	Rules (Criteria)	Plan of Correction	Completion Date
	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** For Resident #1, there was no verification that the dose was given	Left Blank Intentionally	
☒	§11-89-18 Records and reports. (b)(1) During residence, records shall be maintained by the caregiver and shall include the following information: Copies of physician's initial, annual and other periodic examinations, evaluations, medical progress notes, relevant laboratory reports, and a report of re-examination of tuberculosis; **FINDINGS** For Resident #2, Annual TB Evaluations were done The form completed noted that a chest x-ray was done and date of last TB skin test was however, a TB skin test was done Another TB skin test was done Physician noted to re-evaluate in one month. No current TB clearance available. (NOTE: Submit a copy of a current TB clearance for Resident #2 with your plan of correction.)	Left Blank Intentionally	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-89-18 Records and reports. (g)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** Resident #3 was discharged from the DDDH; however, date of discharge was not recorded on the registry.	Left Blank Intentionally	
☒	§11-89-18 Records and reports. (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be submitted to the case manager within twenty-four hours from the time of the incident and shall be retained by the facility under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician shall be called immediately if medical care is necessary. **FINDINGS** For Resident #1, verification was not consistently available to indicate that a copy of the incident report was sent to the DOH case manager	Left Blank Intentionally	

Licensee's/Administrator's Signature: Christine Menezes, Director of Programs + Services

Print Name: Christine Menezes

Date: 3/11/16

§11-89-9 General staff health requirements. (a)(1)

Page 1

Plan of Correction: See attachments 1 and 2. The Human Resource Department misread and documented the wrong dates of Caregiver #1's TB results HR Assistant has been instructed on how to read and document the dates of 2-step results when test are being performed with a primary physician rather than the Department of Heath TB Clinics. The HR Department will continue to have multiple people review documents prior to it being sent to OHCA. **Date of Completion:** February 29, 2016

§11-89-14 Resident health and safety standards. (e)(6)

Page 2

Plan of Correction: Resident #1: The Home manager received in service training on November 5, 2015 regarding scheduling appointments early in the review month to submit the 3 month medication review to the primary physician. Follow up with the physician's office will also be done in a timely manner to make sure that all updates are timely as well. If there are difficulties in working with a particular physician the Home Manager will contact the RN for assistance. In service training with the Home Manager included a reminder to submit an appointment calendar to the RN as well. Paperwork will be filed in a timely fashion with copies sent to the RN for review. In addition, the RN will increase her audits for this home from quarterly to monthly in order to assure that proper protocol and procedure are being followed and that records are being maintained accordingly. A list of corrections will be generated as needed and submitted to the Home Manager with a time line for completion as determined. A follow up visit by the RN or Nursing Manager will be made to verify the corrections. Extra assistance and training will be provided as necessary. **Date of Completion:** November 5, 2015

Plan of Correction: Resident #1: The Home manager received in service training on November ~~15~~ 5 Cm, 2015 regarding scheduling appointments early in the review month to submit the 3 month medication review to the primary physician. Follow up with the physician's office will also be done in a timely manner to make sure that all updates are timely as well. If there are difficulties in working with a particular physician the Home Manager will contact the RN for assistance. In service training with the Home Manager included a reminder to submit an appointment calendar to the RN as well. Paperwork will be filed in a timely fashion with copies sent to the RN for review. In addition, the RN will increase her audits for this home from quarterly to monthly in order to assure that proper protocol and procedure are being followed and that records are being maintained accordingly. A list of corrections will be generated as needed and submitted to the Home Manager with a time line for completion as determined. A follow up visit by the RN or Nursing Manager will be made to verify the corrections. Extra assistance and training will be provided as necessary. **Date of Completion:** November 5, 2015

§11-89-14 Resident health and safety standards. (e)(11)

Page 2

Plan of Correction: The expired bottle was removed and replaced with a refill of the same medication with an expiration date of June 2016. Home staff received in service training regarding checking for the expiration date on medication and rotating medication appropriately. Medication will be discarded as per protocol. The Home Manager will utilize the weekly audit to assure that all medication is correct and properly dated. The RN will increase her audits for this home from quarterly to monthly in order to assure that proper protocol and procedure are being followed and that records are being maintained accordingly. A list of corrections will be generated as needed and submitted to the home manager with a time line for completion as determined. A follow up visit by the RN or Nursing Manager will be made to verify the corrections. Extra assistance and training will be provided as necessary. **Date of Completion:** November 5, 2015

§11-89-14 Resident health and safety standards. (e)(12) Medication

Page 2

Plan of Correction: Staff received in service training regarding the proper documentation and proper protocol for the half hour medication check. The Home Manager is responsible and expected to follow up with staff to ensure that documentation meets proper criteria particularly in regard to documentation of medication and medical treatments. The Home Manager will continue to perform weekly medication audits and advise the staff of corrections that need to be made. Staff will perform a weekly checklist as directed by the Home Manager. The RN will increase her audits for this home from quarterly to monthly in order to assure that proper protocol and procedure are being followed and that records are being maintained accordingly. A list of corrections will be generated as needed and submitted to the Home Manager a time line for completion as determined. A follow up visit by the RN or Nursing Manager will be made to verify the corrections. Extra assistance and training will be provided as necessary. **Date of Completion:** November 5, 2015

§11-89—18 Records and reports. (b)(1)

Page 3

Plan of Correction: A skin test record was obtained See Attachment 3. The original date of the test is noted to be A chest x-ray was performed on See attachment 4. The Primary Physician was faxed a copy of the skin test record and a copy of the chest x-ray for records. Staff received in service training regarding proper TB clearance procedure and maintaining clearance records properly. Nurse will increase her audits for this home from quarterly to monthly in order to assure that proper protocol and procedure are being followed and that records are being maintained accordingly. A list of corrections will be generated as needed and submitted to the Home Manager a time line for completion as determined. A follow up visit by the RN or Nursing Manager will be made to verify the corrections. Extra assistance and training will be provided as necessary. In addition, the RN will pay particular attention to this area to ensure skin tests are not being done erroneously. **Date of Completion:** November 19, 2015

§11-89—18 Records and reports. (g)(1) Miscellaneous records

Page 4

Plan of Correction: The Director of Programs and Services inadvertently missed Resident #3's discharge date when reviewing the homes operations manual. The discharge date for Resident #3 is The Director of Programs and Services as well as the assigned RN for the home will continue with their reviews and pay closer attention to a resident's discharge and ensure the date recorded accordingly. **Plan of Corrections:** March 14, 2016

§11-89—18 Records and reports. (c)

Page 4

Plan of Correction: All unusual incidents that occur in the home will be reported to the DOH case manager by way of an incident report. Administration staff will be responsible for sending the completed report to the DOH case manager. The Arc in Hawaii has been in contact with the Department of Health DD Division as there are DOH Case Management Units who have informed The Arc in Hawaii that incidents reports that are being sent to them are unnecessary because they do not fall under their standards for reportable events. Until The Arc in Hawaii receives clear instructions from the DD Division, all incident reports that fall under unusual circumstance according to The Office of Health Care Assurance guidelines will be submitted to the DOH case manager. **Date of Completion:** April 1, 2016