Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: KeAloha Care Home Inc.	**CHAPTER 100.1**
Address: **3617 Puuku Mauka Drive, Honolulu, Hawaii 96818**	**Inspection Date: January 27, 2015 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** Substitute care giver #1 – No initial two-step tuberculin (TB) clearance.	See attached	1/27/15

11-100.1-9 (b) Upon the hiring of any new employee, KeAloha Care Home will ensure that everyone has an initial two-step PPD clearance or that any current employee has successfully completed one & that it abides by Chapter 11-100 law.

11-100.1-9 Substitute care giver #1 unfortunately was no longer a part of our care team however we made adjustments to our policy and procedure for new hire paperwork. All Substitute Care Giver's are now given a New Hire Packet with all mandatory paperwork due to Human Resource Manager prior to start date on KeAloha Care Team, this is to include the initial two-step tuberculosis(TB) clearance. A Care Team Checklist was created for each person hired and placed in our KeAloha Team Binder with all copies of mandatory forms, clearances and completed trainings and education certificates to have on file for quick and easy reference internally by our Licensee, PCG or by the Dept of Health.

☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. **FINDINGS** Three substitute care givers – No documentation of training by the primary care giver to make prescribed medications available to residents. The documents were not dated.	see attached	1/27/15

11-100.1-9 (e) (4) KeAloha Care Home will ensure that all caregiver training & logging is properly documented & dated. It will be kept in a safe & easily-attainable area to be reviewed as needed (such as the ARCH binder). KeAloha Care Home will also make sure to more adequately log SCG training for any machinery use & or blood sugar checks. I will apply this to any SCG training completed in the care home.

11-100.1-9(e)(4) After our Annual Inspection we decided to revisit training for our entire existing team, choosing to continue utilizing the form ARCH I R 40 to document our training as well as keeping any specialized training provided in the community on hand in order by date. To ensure that all team members are provided concise and consistent training a KeAloha Care Team Training Manual and Protocol was created. This is used for all new hires as well as updated throughout each quarter and upon new needs of our care home so that training will stay current and relevant to our existing residents amongst our team. All documentation of training is kept in the KeAloha Team Binder under each team member's section as well as in the ARCH Binder kept dated, organized, labeled and updated.

☒	§11-100.1-14 Food sanitation. (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies. **FINDINGS** Ph tester solution unsecured at a resident's bedside.	see attached	4/27/15

11-100.1-14(f) Upon Ph tester solution found in resident's bedside, it was properly discarded of. To prevent any future deficiency we have continued to keep adequate area of locked organizational space for medications and toxic chemicals, all of which are labeled and organized. We have consistently enforced bedside checks throughout the normal daily routine of our care home to ensure that all toxic chemicals remain secured and have also reminded family, power of attorney's and visitors of our policy even in regards to any over the counter substances, cleaning supplies etc.

☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – was ordered on 12/18/14; the label reflected Resident #1 – was ordered on 12/18/14; the label reflected Resident #1 – No physician order for found with current medication. Resident #1 – was noted on the physical examination record but not made available. There was no clarification of the order. No documentation why the medication was not made available.	See attached	2/27/15

11-100.1-15 (e) Concluding Annual Inspection in 2015 an appointment with Resident #1 Primary Care Physician was made post inspection to review all medications and supplements, providing clarity to PCG and signing off on new updated Physician Orders so that ALL medications would be kept on a current one. Our team has now been retrained of how to take an immediate change or update to medication by utilizing a phone or fax Physician Order and we have even labeled and kept extra Physician Orders by our phone and fax line. All Physician Orders taken are immediately added to the Medication Administration Record so that they can be carried out promptly as the medicine becomes available from the pharmacy. Any clarification that is needed is immediately sought out and when physician is difficult to get a hold of we continue to use all means of communication such as phone, fax and email to get in touch with them so that the necessary clarity may be signed off on the Physician Order.

	please see attached typed response	3/21/16

☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – was ordered on 12/18/14; the label reflected Resident #1 – was ordered on 12/18/14; the label reflected Resident #1 – No physician order for found with current medication. Resident #1 – was noted on the physical examination	To prevent the deficency in the future, at the first week of the month KCH PCG and KCH Asst. manager will check all Physician's orders and medication labels for congruancy and accuracy.	3/21/16

☒	§11-100.1-15 Medications. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. **FINDINGS** Resident #1 – No medication records for July 2014 and September 2014.	see attached	1/28/15

11-100.1-15(m) We immediately discontinued our previous protocol to transfer Resident Binder documentation into a Resident File Cabinet. This eliminated anything being lost in transfer. We now make sure that all Medication Administration Records that are completed are kept on file only in the Resident's Binder and are not removed until the next year's annual inspection is completed.

☒	§11-100.1-17 Records and reports. (a)(4) 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: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident #1 – No documentation of two-step tuberculosis clearance upon admission. **Submit copy of the second skin test with the plan of correction.**	see attached	2/2/15 read on: 2/4/15

11-100.1-17(a)(4) To correct the needed two-step TB clearance Resident #1 was taken to get a second skin test done. In the future we now know that should the first step be negative that the second step must be a skin test and may not be substituted for a chest x-ray. Only in the event of a positive first step the chest x-ray will need to be documented for proper TB Clearance. We have clarified our understanding of the TB clearance to make sure that admission processing on our part is done efficiently to prevent the deficiency from recurring.

☒	§11-100.1-17 Records and reports. (a)(4) 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: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident #1 – No documentation of two-step tuberculosis clearance upon admission. **Submit copy of the second skin test with the plan of correction.**	To prevent this deficency in the future we have implemented a two-step verification process for both Care Home Operator and Care Home PCG to verify completeness of Admission Checklist and all required documentation.	3/21/16

☒	§11-100.1-17 Records and reports. (a)(6) 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: Physician or APRN signed orders for diet, medications, and treatments;	see attached	2/2/15
	FINDINGS Resident #1 – No physician order for		

11-100.1-17(a)(6) Immediate contact was made with to ensure proper Physician Order for the use of the special equipment was re-attained. To ensure that a similar deficiency would not incur Resident #1's annual appointment as desired by was scheduled to work alongside that specialty physician to obtain and keep on record current Physician Orders

To prevent the deficency in the future, at the first week of the month KCH DG and KCH Asst. manager will check all physician's orders have been signed and implemented.	3/21/16

☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: 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; **FINDINGS** Resident #1 – No monthly progress notes for July 2014, August 2014, September 2014, November 2014 and December 2014. Resident #1 – Progress notes did not reflect monthly weight need for and response to ordered , need for and response to PRN medication performed independently by the resident.	see attached	1/28/15; 2/27/15

11-100.1-17(b)(3) To correct this deficiency Monthly Progress Notes are notated on a specifically created Progress Note that clearly shows all highlights for that month from resident weight, appetite observations, any changes in condition, how they have responded to treatments and new medications ordered. To properly document any need for and response to PRN mediation we have a special checklist that we added to a PRN Medication / Treatment Progress Note that allows are team to successfully document why a PRN medication was needed, how it was responded to and if any further follow up is needed for our resident, this includes any resident's need for special equipment or treatments. We are able to utilize a communication tool that we created for Morning/Afternoon/Evening shifts amongst our team to make sure that members on different days or shifts are aware of the Progress that we are tracking for residents.

☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: 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; **FINDINGS** Resident #1 – No monthly progress notes for July 2014, August 2014, September 2014, November 2014 and December 2014. Resident #1 – Progress notes did not reflect monthly weight , need for and response to ordered need for and response to PRN medication, performed independently by the resident.	To prevent this deficiency from happening in the future during the first week of every month a Routine Resident Progress Note Checklist is implemented by KCH PCG to double-check all progress notes a cover significant progress highlights. 3/21/16

☒	§11-100.1-17 Records and reports. (b)(4) During residence, records shall include: Entries describing treatments and services rendered; **FINDINGS** Resident #1 – No documentation of three (3) times a week.	see attached	1/28/15

11-100.1-17(b)(4) To address the deficiency of documenting special equipment and treatments performed PCG worked directly with Primary Care Physician and Specialty Physician's to ensure the proper Physician Order documentation needed for describing which treatments and services to render. Upon receiving any Physician Orders all special equipment needed or treatments that are performed are properly documented on the Medication Administration Record immediately.

p.9

☒	§11-100.1-17 Records and reports. (g) All information contained in the resident's record shall be confidential. Written consent of the resident, or resident's guardian or surrogate, shall be required for the release of information to persons not otherwise authorized to receive it. Records shall be secured against loss, destruction, defacement, tampering, or use by unauthorized persons. There shall be written policies governing access to, duplication of, and release of any information from the resident's record. Records shall be readily accessible and available to authorized department personnel for the purpose of determining compliance with the provisions of this chapter. **FINDINGS** Resident #1 – Entries on the physician record by the primary care giver for 6/16/14 and 7/10/14 had numerous lines drawn across the word(s) to prevent reading what was under it.	see attached	1/27/15

11-100.1-17 (g) KeAloha Care Home will make sure not to obliterate or cross out any physician orders, even if approved by physician. KeAloha will either have a new physician order filled out or will have the doctor cross out & initial to make sure that it does not appear that document was tampered with.

☒	§11-100.1-23 Physical environment. (p)(5) Miscellaneous: Signaling devices approved by the department shall be provided for resident's use at the bedside, in bathrooms, toilet rooms, and other areas where residents may be left alone. In Type I ARCHs where the primary care giver and residents do not reside on the same level or when other signaling mechanisms are deemed inadequate, there shall be an electronic signaling system. FINDINGS One bedside did not have a signaling device.	see attached	1/27/15

11-100.1-23(p)(5) To immediately correct the deficiency the call button mechanism that was in use was securely screwed into the wall. A secondary system was also installed, resident bedrooms/bedsides will have working & secured signaling devices at all times. This system includes a wall system and pager device that notates visually and verbally exactly what resident room or restroom has been paged. It has a hand-held component that is secured bedside as well for any expanded-level resident(s).

To prevent this deficiency from happening in the future, KCH has implemented signaling device check on Routine Daily Task List, to be performed all trained KCH staff.	3/21/16

Licensee/Administrator's Signature: [signature]

Print Name: Tiara K. Landa | Ashley-Chantel Guzman

Date: 7/29/2015

Licensee/Administrator's Signature: [signature]

Print Name: Ashley-Chantel Guzman

Date: 3/21/16

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

Print Name: Tiara K Landa

Date: 10/13/16