

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 21, 2016 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 Resident health and safety standards. (e)(1) Medications:</p> <p>All medicines shall be properly and clearly labeled. The storage shall be in a staff-controlled workcabinet/workcounter apart from either residents' bathrooms or bedrooms.</p> <p><u>FINDINGS</u></p>	<p>The administering of medication should be by the exact instructions as indicated by the pharmacy label. The caregiver was retrained to follow these instructions. The case manager will review the medication record and check for discrepancies to ensure that the medication instructions is correctly administered.</p>	8/11/2016
		<p>The care was retrained by the case manager to make sure that the medication's label corresponds with the physician's order. The case manager will follow up with rechecking the medical labels of medication on the 15th and the 30th of each month to make sure it matches the physician's order.</p>	9/13/16

	<input checked="" type="checkbox"/> §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.			
	<u>FINDINGS</u>	<p>To ensure accurate documentation, the case manager will review the corresponding medical records per client and ensure that documentation is free of error before submitting it to physician for review and signature.</p>	<p>8/11/2016</p>	
		<p>Medication updates were checked to ensure they correspond with the medication label and the physician's order. Records will be checked on the 15th and the 30th of each month. Errors will be followed by in-service training from the nurse until errors are corrected.</p>	<p>9/12/16</p>	

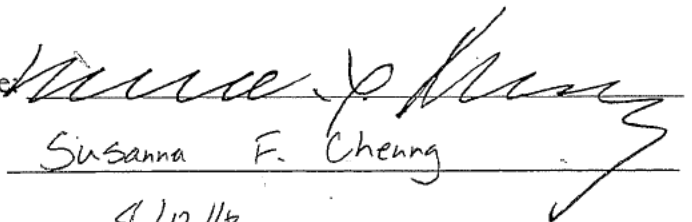
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (e)(12) Medications:</p> <p>All medications and supplements, such as vitamins, minerals, and formulas, shall have written physician's orders and shall be labeled according to pharmaceutical practices for prescribed 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.</p>	<p>To ensure accurate documentation, the case manager will review the medical record and ensure that the description corresponds free of error with pharmacy label before submitting it to caregiver</p>	<p>8/11/2016</p>
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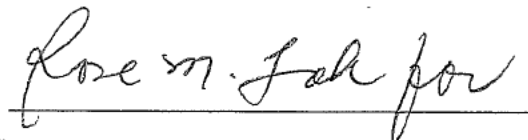
	<p><u>FINDINGS</u></p>	<p>It was reminded to the case manager that on the 15th and 30th of every month will check the medical records of the caregiver to ensure that the documentation corresponds with the medication label and with the physician's order and/or 3 months medication update. Any found error will be followed by in-service training from staff nurse to reduce errors.</p>	<p>9/12/16</p>
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<input checked="" type="checkbox"/>	<p>§11-89-16 <u>Admission policies.</u> (b)(2) The caregiver shall coordinate with the division for screening, placement, and case management prior to admission.</p> <p>All individual plans shall be monitored and revised at least annually and as necessary by the case manager.</p> <p><u>FINDINGS</u> For Resident #1, a copy of a current Individualized Service Plan was not in the resident's file.</p>	<p>The case manager was reminded to keep a current ISP for each client in the residents file. ORI case manager had a copy of ISP but it was not filed. ISP was filed in the resident medical record on 7/21/2016.</p>	<p>7/23/16</p>
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (a)(4) Individual records shall be maintained for each resident. Upon admission or readmission, the facility shall maintain:</p> <p>An inventory of money and valuables. This inventory shall be kept current.</p> <p><u>FINDINGS</u> For Resident #1, the inventory on file did not have a date of completion. Unable to determine if the inventory was current.</p>	<p>For proper timeliness, The Caregiver will include the date of completion when finishing inventory to ensure that inventory is current. The case manager was further reminded to check inventory for date of completion when submitted.</p>	<p>8/11/2016</p>
		<p>The inventory for Client #1 was given back to caregiver for retraining by case manager and was properly dated on 6/01/16. The caregiver was reminded to properly date inventory when submitted. Case manager will follow up and retrain if discrepancies persist.</p>	<p>9/13/16</p>

<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (b)(2) During residence, records shall be maintained by the caregiver and shall include the following information:</p> <p>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;</p> <p><u>FINDINGS</u> For Resident #1, caregiver entries did not consistently indicate the dates and/or times medications were given and/or treatments were rendered:</p>	<p>The caregiver was reminded to submit entries with the date and time that medication is rendered as well as the proper date and full signature.</p> <p>The case manager will review the caregiver entries, including the checking of the date and time that medication is rendered as well as the proper date and full signature. This will be done at least once a month and when additional notation is made.</p>	<p>8/11/2016</p>
		<p>The case manager retrained the caregiver to properly label the date and time of the PRN medication used. If future deficiencies persist, the case manager will again retrain the caregiver and return the caregiver entry for proper date and time.</p>	<p>9/12/16</p>

<input checked="" type="checkbox"/> §11-89-18 <u>Records and reports.</u> (e)(1) General rules regarding records: All entries in the resident's records shall be written in blue or black ink, or typewritten, shall be legible, dated, and signed with full signature and title by the individual making the entry; <u>FINDINGS</u>	<p>The case manager will review the caregiver entries to include the proper date of documentation. This will be done at least once a month and when additional notation is made.</p>	<p>8/11/2016</p>
	<p>The case manager retrained the caregiver to properly date monthly records and to use full signature. The case manager will again retrain the caregiver if caregiver entries continue without date and full signature</p>	<p>9/13/16</p>

Licensee's/Administrator's Signature: 
 Print Name: Susanna F. Cheung
 Date: 8/12/16

Licensee's/Administrator's Signature: 
 Print Name: Susanna F. Cheung, President / CEO
 Date: 9-15-2016