Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: The Arc in Hawaii – Wahiawa B (DDDH)	**CHAPTER 89**
Address: **140 B Kuahiwi Avenue, Wahiawa, Hawaii 96786**	**Inspection Date: August 25, 2016**

	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 For Resident #1, 3-month medication updates were untimely for the following:	The Primary Physician will not sign postdated documents therfor the correction could not be made. Home manager received in service training from the nurse regarding preparing for and scheduling timely updates for the three month medication reviews. To assist the home manager in tracking the updates at proper intervals was provided with a tickler on which to record the information. The tickler should be kept with appointment calendar and additionally may be copied and placed in the front of the 3-month review tab as a reminder. See attachment 1. The nurse will continue quarterly audits and make written recommendations for changes and corrections. will follow up on the corrections with the home manager and appropriate staff members. The Nursing Manager will provide oversight and conduct random quarterly audits of the client records.	August 26, 2016

	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**	Home manager received in service training by the nurse regarding proper review of physician orders, seeking corrections promptly, and transcription of orders to the medication record. Home manager verified D.O. order and new medication was ordered to match the correct order. The dosing instructions were corrected in the medication record. The Primary Physician was also contacted regarding the change in medication dosing so that records are updated as well. The nurse will continue quarterly audits and make written recommendations for changes and corrections. will follow up on the corrections with the home manager and appropriate staff members. The Nursing Manager will provide oversight and conduct random quarterly audits of the client records. Staff verified with the Nurse that the medications were administered as directed, no medication error occurred. Staff have been re-trained by nurse to conduct their 30-minute medication checks after medications are given to ensure medications were given and proper documentation was completed. The Home Manager will also continue to complete the weekly home monitoring checklist which includes checking the medication records. See attachment 2.	September 12, 2016
☒	§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		

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	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**	The individuals who are responsible for contacting the Department of Health Case Manager have been told to report or make contact within a 24-hour period of the incident occurring. They have also been instructed to send the incident report to the Case Manager regardless if they are told one does not need to be sent. A completed copy of the incident report which includes the verification of the case manager being contacted will be sent to the home.	September 14, 2016
☒	§11-89-18 Records and reports. (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; **FINDINGS**	As part of the Home Manager's weekly audit, the Manager has been reminded of the need to go through the entries to ensure full signatures are present ~~and not initials.~~ or ~~initials~~ It is the responsibility of the Home Manager to notify the staff of the missing signature and to ensure that it is documented accordingly. The Nurse will check the entries for any ~~missing initials~~ on signatures on a quarterly basis and the Director of Programs and Services will check at least once a year.	September 14, 2016

Licensee's/Administrator's Signature: Christine Menezes, DPS

Print Name: Christine Menezes

Date: September 14, 2016

Licensee's/Administrator's Signature: Christine Menezes DPS

Print Name: Christine Menezes

Date: October 3, 2016