

Office of Health Care Assurance

State Licensing Section

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Pat's ARCH	CHAPTER 100.1
Address: 91-1029 Hanakahi Street, Ewa Beach, Hawaii 96706	Inspection Date: June 3, 2016 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.</p> <p>FINDINGS spray, currently in use, was not stored in an upright position per package instructions.</p>	<p>Placed a note/label on spray to store upright. To prevent similar deficiency, I will make sure that we always read the package instructions for any and all special handling or each medication. Educating all substitute care givers (SCG) on medication special handling to ensure that this deficiency does not recur will be practiced.</p>	6/3/2016
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (c) Separate compartments shall be provided for each resident's medication and they shall be segregated according to external or internal use.</p> <p>FINDINGS Internal and external medication were not segregated.</p>	<p>External medication were placed in a ziploc bag. I will make sure to separate external and internal medication through placing them into Ziploc bags or another container with label to prevent similar deficiency. Educating all SCG to separate medications will avoid recurrence.</p>	6/3/2016

	Rules (Criteria)	Plan of Correction	Completion Date
☒	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p>FINDINGS Resident #1 – Medication record reflected taken however, breakfast served at should be taken at</p>	<p>To prevent similar deficiency, I will see to it that I will read package instruction for special administration. In the event that resident refuses to take medication on appropriate time, I will discuss the situation with PCP. Educating all SCG on special administration of medication to ensure that medication are given on proper time.</p>	6/4/2016
☒	<p>§11-100.1-15 <u>Medications.</u> (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.</p> <p>FINDINGS Resident #1 – No physician order</p> <p>Resident #1 – found with current medication, had expiration date</p>	<p>Got clarification for medication from PCP indicating that is the same as dispense by pharmacy. Discontinued medication was removed from current supplies of medication. Always get clarification with PCP regarding medication dispense by pharmacy to prevent the same deficiency. Make a once-a-month or some routine to check all medication to ensure all medication are current to ensure that there is no recurrence.</p>	6/3/2016
☒	<p>§11-100.1-17 <u>Records and reports.</u> (a)(1) 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:</p> <p>Documentation of primary care giver's assessment of resident upon admission;</p> <p>FINDINGS Resident #1 – Admission assessment, using the Admission</p>	<p>Completed Admission Assessment for resident. To prevent similar deficiency, I will ensure to complete assessment upon admission before filing documents. I will review all documents on the day of admission before filing them onto resident's folder to ensure that nothing is missed and that important forms are filled and completed to prevent from happening again.</p>	6/3/2016

	Rules (Criteria)	Plan of Correction	Completion Date
	<u>Assessment/Plan of Care</u> form was incomplete		
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (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:</p> <p>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;</p> <p>FINDINGS Resident #1 – _____ The date that the second _____ was read was not documented.</p>	<p>Completed the _____ for resident #1. To prevent similar deficiency, I will share the admission list to both family, case manager, or social worker at least two (2) days prior to admission for review to make sure everything is complete. To prevent recurrence, I will review all documents are filled and/or completed prior to admission to have enough time to get everything completed.</p>	<p>8/19/2016 8/29/2016</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (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:</p> <p>Physician or APRN signed orders for diet, medications, and treatments;</p> <p>FINDINGS Resident #1 – No signed physician orders at the time of admission</p>	<p>To prevent similar deficiency from happening, I will review all documents for completeness including physician's orders for medications, diet, and treatments. Routine review of documents filed on the resident's folder and placing tabs for incomplete documents will be practiced by me and all SCG to make sure that it doesn't recur.</p>	<p>6/3/2016</p>

	Rules (Criteria)	Plan of Correction	Completion Date
☒	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>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;</p> <p><u>FINDINGS</u> Resident #1 – No progress notes</p>	<p>Late entry on progress note . Documenting on progress note and not just completing an incident report will make sure that all documentation is complete. Writing on both forms and making some notation like post it as a reminder to complete documents before filing will ensure that either me or all SCG will be reminded until completed will prevent recurrence.</p>	6/4/2016
☒	<p>§11-100.1-17 <u>Records and reports.</u> (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 made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary.</p> <p><u>FINDINGS</u> Resident #1 – Incident reports were in the resident record.</p>	<p>Removed incident reports for resident #1 from records/binder and placed them on EARCH record/binder. Educate SCG that all incident reports should be included to carehome records. To prevent future recurrence, a routine review of records/binder will be practiced to ensure that documents are in proper</p>	6/3/2016
☒	<p>§11-100.1-23 <u>Physical environment.</u> (i)(3)(B) All construction or alterations shall comply with current county building, land use and fire codes and ordinances in the state. The Type I ARCH licensed for wheelchair residents</p>		

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	<p>shall be accessible to and functional for the residents at the time of licensure.</p> <p>Doors:</p> <p>When multiple locking devices are used on exits, a maximum of two locking mechanisms for egress shall be allowed;</p> <p><u>FINDINGS</u> Front exit door had three locking devices. In addition, the deadbolt locking device on the solid wood door was difficult to unlock.</p>	<p>Removed one locking device on the front exit door (leaving only two) and the deadbolt locking device was adjusted to make it easier to lock and unlock. To prevent recurrence, I will check all door mechanisms during fire drill and make necessary adjustment if needed. All worn out locking device will be check by me and other SCG to make sure that it is working properly for safety.</p>	6/4/2016
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (o)(3)(B) Bedrooms:</p> <p>Bedroom furnishings:</p> <p>Each bed shall be supplied with a comfortable mattress cover, a pillow, pliable plastic pillow protector, pillow case, and an upper and lower sheet. A sheet blanket may be substituted for the top sheet when requested by the resident;</p> <p><u>FINDINGS</u> Resident's pillows did not have pliable plastic pillow protectors.</p>	<p>Resident's pillows were labeled with resident's name and recorded them on their inventory. Implement a policy change to prevent recurrence that new pillow will be given to each resident's at the time of admission. Label and write resident's name on the pillow and either give the pillow or discard at the time of discharge.</p>	6/3/2016
<input checked="" type="checkbox"/>	<p>§11-100.1-83 <u>Personnel and staffing requirements.</u> (1) In addition to the requirements in subchapter 2 and 3:</p> <p>A registered nurse other than the licensee or primary care giver shall train and monitor primary care givers and substitutes in providing daily personal and specialized care to residents as needed to implement their care plan;</p>		

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	<u>FINDINGS</u> Substitute care giver (SCG) #1 – No documentation of training by the RN case manager. Submit a copy with the plan of correction.	All required training for SCG #1 are completed. To prevent recurrence and mishandling of completed training documentation, review all training for each caregivers. At the time of training, check and make sure that RN or Case Manager signed all training to ensure it's completed. Documents attached.	6/4/2016

Licensee's/Administrator's Signature: 

Print Name: PATRICIA U. NUNEZ

Date: 10/20/16