Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: The Arc in Hawaii – Lusitana B (DDDH)	CHAPTER 89
Address: 1660B Lusitana Street, Honolulu, Hawaii 96813	Inspection Date: November 16, 2016

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

	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** For Resident #1, take 1 every 6 hours as needed was ordered It was not listed on the November 2016 medication record.	**Part 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	11-89-14(e)(12)	**Part 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** The Nurse will conduct an in service training with the Home Manager regarding updating the medication record. In service training will include the following topics: 1) Reviewing preprinted medication records and correcting any errors upon receipt 2) Verifying changes and providing updated information to Pharmacare as soon as possible, 3) Notifying the Nurse of any changes, corrections, or omissions. The Nurse will continue to review the medication records when they are delivered by Pharmacare and will note discrepancies based on the most current updates before distributing them to the home. The Nurse will follow up within 72 hours regarding any discrepancies to verify that correction have been made and any issues have been resolved. The Nurse will continue her quarterly audits and make written recommendations for changes and corrections. She will follow up on the corrections with the home manager and appropriate staff members within 10 days of the initial inspection. The Nursing Manager will provide oversight and conduct random quarterly audits of the client records to assure continuity.	12/16/16

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	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-89-18 Records and reports. (b)(2) During residence, records shall be maintained by the caregiver and shall include the following information: 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; FINDINGS For Resident #1, physician ordered The caregiver entry of October 8, 2016 reflected the order ; however, thereafter, there were no caregiver entries to reflect that the were being done and/or reflecting resident's response to treatment. The caregiver note of October 14, 2016 indicated that the physician noted improvement There were no subsequent caregiver entries to indicate the status whether were still being done and/or whether	Part 1 **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	11-89-18(b)(2)	**Part 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** The Nurse will provide in service training for all staff regarding proper documentation of wound treatment and healing. In service training will include the following topics: 1)Initial observations and physician orders 2)Documentation of treatment provided including observations of changes in wound size, color, shape, discharge, and healing 3) Resident response to treatment ie pain level, cooperation 4) Frequency of documentation 5) Reporting changes to physician/nurse The Nurse will follow up on any injuries within 24 hours of occurrence to verify severity and course of treatment including documentation. Over the course of treatment the nurse will randomly check documentation for accuracy and depth. The Nurse will continue her quarterly audits and make written recommendations for changes and corrections. She will follow up on the corrections with the home manager and appropriate staff members within 10 days of the initial inspection. The Nursing Manager will provide oversight and conduct random quarterly audits of the client records to assure continuity.	12/16/16

Licensee's/Administrator's Signature: ____________________ DPS

Print Name: Christine Menezes

Date: December 6, 2016