

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name:</b> ARC of Maui County – Molokai Residence Hale Maunaloa (DDDE)	<b>CHAPTER 89</b>
<b>Address:</b> 24 Hoalua Street, Maunaloa, Hawaii 96770	<b>Inspection Date:</b> October 21, 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
<input checked="" type="checkbox"/>	11-89-8(d)	<p style="text-align: center;">Part 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>Refer to attached</i></p>	<p style="text-align: center;"><i>11/8/16</i></p> <p style="text-align: right;"><i>RESOLVED</i></p> <p style="text-align: right;"><i>16 NOV 10 P1:19</i></p>

- **Rule (Criteria)**  
11-89-8 Provision for services and review (d)

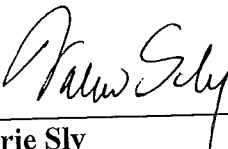
**Corrective Action Future Plan Part 2:**

To prevent recurrence, all required in-service documentation for Certified Caregivers will be placed in the staff training binder immediately following the training. The training binder will continue to be located in the facility. The Residential Manager will monitor the training binder on a quarterly basis to ensure satisfaction of the in-service requirement for all Certified Caregivers.

**Effective Date:** 11/8/16

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	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (e)(4)  Medications:</p> <p>All poisons shall be plainly labeled and stored separately in a locked cabinet.</p> <p><b><u>FINDINGS</u></b>  Windex spray was found unsecured in one resident's bathroom cabinet.</p>	<p style="text-align: center;">Part 1</p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>Refer to attached</i></p>	<p style="text-align: right;"><i>10/21/16</i></p> <p style="text-align: right;">16 NOV 10 P 1:19</p> <p style="text-align: right;"><i>Transcript</i></p> <p style="text-align: right;"><i>PROVIDE</i></p>

- **Rule (Criteria)**

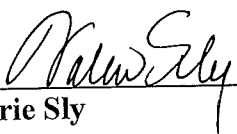
11-89-14 Resident health and safety standards (e)(4)

**Corrective Action Plan Part 1:**

The Windex was immediately removed from the resident's bathroom cabinet and placed in the locked cabinet with the other cleaning supplies.

**Effective Date:** 10/21/16

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	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	11-89-14(e)(4)	<p style="text-align: center;">Part 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>Refer to attached</i></p>	<p style="text-align: center;"><i>10/21/16</i></p> <p style="text-align: right;"><i>APPROVED</i></p> <p style="text-align: right;"><i>16 NOV 10 P1:19</i></p> <p style="text-align: right;"><i>Ben S. A. [unclear]</i></p>

- **Rule (Criteria)**

11-89-14 Resident health and safety standards (e)(4)

**Corrective Action Future Plan Part 2:**

To prevent recurrence, all other bathroom and kitchen cabinets were checked for incorrect storing of hazardous cleaning supplies and no other issues were identified. Staff was retrained regarding the requirement to have all hazardous cleaning supplies locked in a cabinet for resident safety.

**Effective Date:** 10/21/16

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Valerie Sly  
Valerie Sly

11/8/16  
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	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (e)(5) Medications:</p> <p>All medications and supplements, such as vitamins, minerals, and formulas shall be made available by written physician order and shall be based upon current evaluation of the resident's condition.</p> <p><b><u>FINDINGS</u></b> For Resident #1, on March 24, 2016, the physician ordered Tylenol every 4 hours as needed for pain or fever. The order did not indicate the strength and/or dosage of the Tylenol.</p>	<p style="text-align: center;">Part 1</p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p style="text-align: right;">16 NOV 10 P1:19</p> <p style="text-align: right;">MORNINGSTAR</p>

	Rules (Criteria)	Plan of Correction	Completion Date
☒	11-89-14(e)(5)	<p style="text-align: center;">Part 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>Refer to attached</i></p>	<p style="text-align: center;"><i>11/8/16</i></p> <p style="text-align: right; font-size: small;">RECEIVED NOV 10 P1:19 DANIELA L...</p>

- **Rule (Criteria)**  
11-89-14 Resident health and safety standards (e)(5)

**Corrective Action Future Plan Part 2:**

The physician order did not include strength or dosing information for Tylenol ordered for Resident #1. The physician prescribed OTC Tylenol as needed on the appointment slip. No prescription was submitted to the pharmacy and staff failed to request this of the physician, which is the typical protocol.

To prevent recurrence, staff was retrained by the Resident Manager to review appointment slips from the medical provider when attending resident medical appointments. This will ensure all required information is included and, when medications are prescribed, staff is to request the physician submit a prescription to the pharmacy.

To monitor this corrective action, the Resident Manager will review all appointment slips after each medical appointment to ensure accuracy and follow-through with the physician's recommendations.

**Effective Date:** 11/8/16

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Date

	Rules (Criteria)	Plan of Correction	Completion Date
<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><b><u>FINDINGS</u></b> For Resident #1, from March 25-29, 2016, and on April 2, 2016, staff gave resident Robitussin Cough/Chest DM Max 10-200mg/5ml oral liquid. The times Robitussin was given were not indicated on the medication records.</p>	<p>Part 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p>16 NOV 10 P1:19</p> <p>RECEIVED</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>11-89-14(e)(12)</p> <p><b><u>FINDINGS</u></b>            For Resident #1, from March 25-29, 2016, and on April 2, 2016, staff gave resident Robitussin Cough/Chest DM Max 10-200mg/5ml oral liquid. The times Robitussin was given were not indicated on the medication records.</p>	<p style="text-align: center;"><b>Part 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR            FUTURE PLAN: WHAT WILL YOU DO TO            ENSURE THAT IT DOESN'T HAPPEN            AGAIN?</b></p> <p style="text-align: center;"><i>Refer to attached</i></p>	<p style="text-align: center;"><i>12/15/16</i></p>

*Arc of Maui County*  
**Hale Maunaloa**  
**Plan of Correction Revisions**  
December 2016

**Annual Inspection:** 10/21/16

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• **Rule (Criteria)**

11-89-14 Resident health and safety standards (e)(12)

**Corrective Action Future Plan Part 2:**

The medication administration time was not documented on the medication record for Robitussin Cough/Chest DM Max PRN for Resident #1.

To prevent recurrence, all staff was retrained by the agency RN regarding the requirement to document the time the PRN medication was administered.

To monitor this corrective action and to ensure correct implementation of the required documentation, the Resident Manager will review the medication record twice weekly for a period of two months. After two months of satisfactory results, the Resident Manager will review the medication record monthly and the agency RN will review the medication record quarterly, both on an ongoing basis. Should the medication record not be satisfactory after two months, bi-weekly reviews will resume for another two month period and in-service training will be provided. Monthly and quarterly reviews will be ongoing by the Resident Manager and the agency RN as stated.

**Effective Date:** 12/15/16

  
Valerie Sly

  
Date

	Rules (Criteria)	Plan of Correction	Completion Date
<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><b><u>FINDINGS</u></b> For Resident #1, the March 2016 medication record notes, "Instill 1-5 drops into each ear BID, use for maximum 7 days." The name of the ear drops, Debrox 6.5% Solution, which was instilled from March 25-31, 2016, was not noted on the medication record.</p>	<p>Part 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p>RECEIVED NOV 10 11 19</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>11-89-14(e)(12)</p> <p><b><u>FINDINGS</u></b>            For Resident #1, the March 2016 medication record notes, "Instill 1-5 drops into each ear BID, use for maximum 7 days." The name of the ear drops, Debrox 6.5% Solution, which was instilled from March 25-31, 2016, was not noted on the medication record.</p>	<p style="text-align: center;">Part 2</p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR            FUTURE PLAN: WHAT WILL YOU DO TO            ENSURE THAT IT DOESN'T HAPPEN            AGAIN?</b></p> <p style="text-align: center;"><i>Refer to attached</i></p>	<p style="text-align: center;"><i>12/15/16</i></p>



- **Rule (Criteria)**

11-89-14 Resident health and safety standards (e)(12)

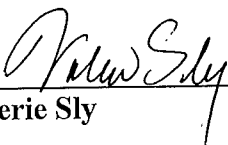
**Corrective Action Future Plan Part 2:**

Debrox ear drops were administered for Resident #1 as prescribed. However, the medication record did not include the name of the ear drops. Therefore, the medication record did not match the physician's order.

To prevent recurrence, the Resident Manager was retrained by the agency RN regarding the importance of required documentation on the medication record and the correct transfer of information from the physician's orders to ensure all information is accurate. All staff was retrained by the Resident Manager regarding the importance of following the "five rights", specifically in regard to ensuring the name of the medication is included on the medication record and matches the name of the medication being administered.

To monitor this corrective action, the agency RN will cross-reference the medication record against the physician's orders for the next two months at the beginning of the month when the new medication record is implemented for the new month. After two months with satisfactory results, the Resident Manager will review the medication record and the physician's orders monthly and the agency RN will review quarterly, both on an ongoing basis, to ensure medications are accurately documented. Should the medication record review not be satisfactory after two months, the agency RN will resume monthly monitoring for another two month period and in-service training will be provided by the agency RN. Monthly and quarterly reviews will be ongoing by the Resident Manager and the agency RN as stated.

**Effective Date:** 12/15/16

  
Valerie Sly

12/15/16  
Date

	Rules (Criteria)	Plan of Correction	Completion Date
<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><b><u>FINDINGS</u></b> For Resident #1, on November 29, 2015 at 8 am, there was no caregiver initial to verify that Mupirocin 2% Ointment was applied.</p>	<p>Part 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p>16 NOV 10 P 1:19</p> <p>RECEIVED</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>11-89-14(e)(12)</p> <p><b><u>FINDINGS</u></b>            For Resident #1, on November 29, 2015 at 8 am, there was no caregiver initial to verify that Mupirocin 2% Ointment was applied.</p>	<p style="text-align: center;"><b>Part 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR            FUTURE PLAN: WHAT WILL YOU DO TO            ENSURE THAT IT DOESN'T HAPPEN            AGAIN?</b></p> <p style="text-align: center;"><i>Refer to attached</i></p>	<p style="text-align: center;"><i>12/15/16</i></p>

- **Rule (Criteria)**

11-89-14 Resident health and safety standards (e)(12)

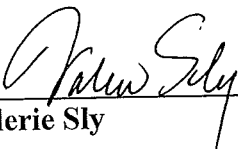
**Corrective Action Future Plan Part 2:**

Mupirocin Ointment was applied for Resident #1. However, staff failed to include their initials on the medication record to document that the medication was administered.

To prevent recurrence, the staff in question was retrained by the Resident Manager, regarding the requirement for including initials on the medication record, which documents all medications administered.

To monitor this corrective action, the Resident Manager will review twice weekly for a period of two months, staff's correct implementation of medication administration, specifically in regard to documenting the medication record with initials. After two months with satisfactory results, the Resident Manager will review the medication record monthly on an ongoing basis. Should the medication record review not be satisfactory after two months, bi-weekly reviews will resume for another two month period and in-service training will be provided. Monthly and quarterly reviews will be ongoing by the Resident Manager as stated.

**Effective Date:** 12/15/16

  
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Valerie Sly

12/15/16  
Date

	Rules (Criteria)	Plan of Correction	Completion Date
<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><b><u>FINDINGS</u></b> For Resident #1, on November 24, 2015 and November 29, 2015, there were no caregiver initials to verify that Terbinafine HCL 1% Cream was applied at 8 am.</p>	<p>Part 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p>16 NOV 10 P 1:19</p> <p>APPROVED</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>11-89-14(e)(12)</p> <p><b><u>FINDINGS</u></b>  For Resident #1, on November 24, 2015 and November 29, 2015, there were no caregiver initials to verify that Terbinafine HCL 1% Cream was applied at 8 am.</p>	<p style="text-align: center;">Part 2</p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p style="text-align: center;"><i>Refer to attached</i></p>	<p style="text-align: center;"><i>12/15/16</i></p>

- **Rule (Criteria)**

11-89-14 Resident health and safety standards (e)(12)

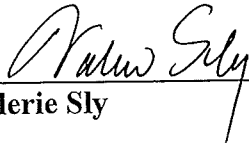
**Corrective Action Future Plan Part 2:**

Terbinafine HCL Cream was applied for Resident #1. However, staff failed to include their initials on the medication record to document that the medication was administered.

To prevent recurrence, all staff was retrained by the Resident Manager, regarding the requirement for including initials on the medication record, which documents all medications administered.

To monitor this corrective action, the Resident Manager will review twice weekly for a period of two months, staff's correct implementation of medication administration, specifically in regard to documenting the medication record with initials. After two months of satisfactory results, the Resident Manager will review the medication record monthly and the agency RN will review the medication record quarterly, both on an ongoing basis. Should the medication record review not be satisfactory after two months, bi-weekly reviews will resume for another two month period and in-service training will be provided. Monthly and quarterly reviews will be ongoing by the Resident Manager and the agency RN as stated.

**Effective Date:** 12/15/16

  
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Valerie Sly

12/15/16  
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	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 Resident health and safety standards. (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><b><u>FINDINGS</u></b> For Resident #1, on March 24, 2016, physician ordered Tylenol every 4 hours as needed for pain or fever. Tylenol was not reflected on the medication records. There was no physician order to discontinue its use.</p>	<p>Part 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p>16 NOV 10 P 1:19</p> <p>RECEIVED</p>



	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	11-89-14(e)(12)	<p style="text-align: center;">Part 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>Refer to attached</i></p>	<p style="text-align: center;"><i>11/8/16</i></p> <p style="text-align: right;">RECEIVED 16 NOV 10 P1:19 DUN SUBA LICENSING</p>

• **Rule (Criteria)**

11-89-14 Resident health and safety standards (e)(12)

**Corrective Action Future Plan Part 2:**

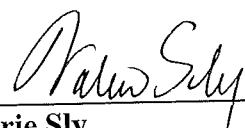
Tylenol PRN was ordered for Resident #1. However it was not reflected on the medication record and there was no physician order to discontinue its use. The physician prescribed OTC Tylenol as needed on the appointment slip. No prescription was submitted to the pharmacy and staff failed to request this of the physician, which is the normal protocol.

To prevent recurrence, staff was retrained by the Resident Manager to review appointment slips from the medical provider when attending resident medical appointments. This will ensure all required information is included and, when medications are prescribed, staff is to request the physician submit a prescription to the pharmacy.

To monitor this corrective action, the Resident Manager will review all appointment slips after each medical appointment to ensure accuracy and follow-through with the physician's recommendations.

**Effective Date:** 11/8/16

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11/8/16  
Date

	Rules (Criteria)	Plan of Correction	Completion Date
<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><b><u>FINDINGS</u></b>            For Resident #1, on November 11, 2015, physician ordered Mupirocin 2% Ointment, wash affected arm then apply thin film to dry skin BID until healed, and Terbinafine HCL 1% Cream, apply to affected area, clean dry area twice daily for two weeks. There were no caregiver entries describing resident's response to treatment.</p>	<p style="text-align: center;">Part 1</p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p style="text-align: right;">16 NOV 10 P1:19</p> <p style="text-align: right;">FINDINGS</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	11-89-18(b)(2)	<p>Part 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>Refer to attached</i></p>	<p><i>12/15/16</i></p>

- **Rule (Criteria)**

11-89-18 Records and reports (b)(2)

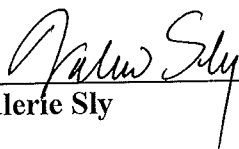
**Corrective Action Future Plan Part 2:**

In review of this issue, Mupirocin Ointment and Terbinafine HCL Cream for Resident #1 were administered in accordance with the physicians order. The medications were effective. However, the response to treatment was not documented as required.

To prevent recurrence, all staff was retrained by the Resident Manager, regarding the requirement to document the residents' response to treatment in the caregiver notes. A new memo regarding this requirement was placed in the front of the medication record to remind staff to ensure resident response to treatments is documented.

To monitor this corrective action, the Resident Manager will monitor twice weekly for a period of two months, staff's correct implementation of the requirement to document resident's response to treatments in the caregiver notes. After two months of satisfactory results, the Resident Manager will review and cross reference the PRN administration and new medications with the caregiver notes on an ongoing monthly basis to ensure response to treatments is documented correctly. Should the documentation review not be satisfactory after two months, bi-weekly reviews will resume for another two month period and in-service training will be provided. Monthly reviews will be ongoing by the Resident Manager as stated.

**Effective Date:** 12/15/16

  
Valerie Sly

12/15/16  
Date

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports</u>, (b)(5)            During residence, records shall be maintained by the caregiver and shall include the following information:</p> <p>Physician's signed orders for diet, medications, special appliances, adaptive equipment, and treatments;</p> <p><u>FINDINGS</u>            For Resident #1, a diet order was not found.</p>	<p>Part 1</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>Reports attached</i></p>	<p><i>11/4/16</i></p> <p>16 NOV 10 P 1:20</p> <p>UNIVERSITY</p>

- **Rule (Criteria)**  
11-89-18 Records and reports (b)(5)

**Corrective Action Plan Part 1:**

A regular diet order was obtained by the physician for Resident #1. Documentation was reviewed for the other residents in the home to ensure documented evidence of diet orders and no orders were identified for the other residents. Regular diet orders were obtained from the physician for the other residents in the home.

**Effective Date:** 11/4/16

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Valerie Sly

11/8/16  
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<input checked="" type="checkbox"/>	11-89-18(b)(5)	<p style="text-align: center;">Part 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>Refer to attached</i></p>	<p style="text-align: center;"><i>11/4/16</i></p> <p style="text-align: right;">16 NOV 10 P1:20</p> <p style="text-align: right;">RECEIVED</p>



- **Rule (Criteria)**

11-89-18 Records and reports (b)(5)

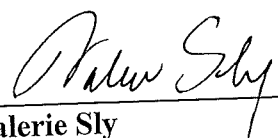
**Corrective Action Future Plan Part 2:**

To prevent recurrence, a review of the issue determined that the Resident Manager had been asked by the Department of Health Case Manager, to use their physical exam form, which did not include a space for the physician to document "regular" or "special" diet. The form was replaced with another physical exam form that includes a space for this information.

The Resident Manager was retrained by the agency RN, regarding the requirement to obtain a diet order from the resident's physician prior to or upon admission and annually at their annual physical. The diet order should be documented on the annual physical form. In addition, the Resident Manager will include the diet order on the 90-day updates.

**Effective Date:** 11/8/16

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Date

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (e)(2) General rules regarding records:</p> <p>Erasures and white outs shall not be permitted;</p> <p><b><u>FINDINGS</u></b> For Resident #1, white out was used on the account records from January 2016 – September 2016.</p>	<p>Part 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p>16 NOV 10 P1:20</p> <p>REDACTED</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	11-89-18(e)(2)	<p style="text-align: center;">Part 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>Refer to attached</i></p>	<p style="text-align: center;"><i>11/8/16</i></p> <p style="text-align: right; font-size: small;">RECEIVED 16 NOV 10 P1:20 MICHIGAN COURT</p>

• **Rule (Criteria)**

11-89-18 Records and reports (e)(2)

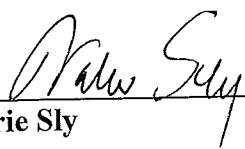
**Corrective Action Future Plan Part 2:**

The Resident Manager was aware of the "no white-out" rule for documentation including the medication record, Incident Reports, caregiver notes, etc. However, this requirement was not correctly applied to the resident account records which were combined.

To prevent recurrence, resident account records are now documented separately for each resident and no white-out is used. The Resident Manager was retrained by the administrator, regarding the requirement to cross out and initial errors rather than use white-out on all resident records.

**Effective Date:** 11/8/16

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Licensee's/Administrator's Signature:

*R. E. Lane / Robert Sly*

Print Name:

Robert Lane / VMEESLY

Date:

11/8/16

Licensee's/Administrator's Signature:

*R. E. Lane / Robert Sly*

Print Name:

Robert Lane / VMEESLY

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