Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Felarca Care Home	**CHAPTER 100.1**
Address: 4679 Likini Street, Honolulu, Hawaii 96818	**Inspection Date: March 11, 2016 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-15 Medications. (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident. **FINDINGS** Resident #1 physician prescribed medications Melatonin, Latanoprost, and Timolol not documented on March medication administration record (MAR) on 3/4/16-3/10/16.		4-1-16
☒	§11-100.1-15 Medications. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. **FINDINGS** Resident #1 discontinued medications Docusate Sodium and Tylenol listed on March medication administration record (MAR) but discontinued on 1/11/16.		4-1-16

☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: 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; **FINDINGS** Resident #1 missing monthly progress notes from September 2015 through February 2016.		4-1-16

Licensee's/Administrator's Signature: Essie Felarca

Print Name: Essie Felarca

Date: 5-11-16

11-100.1-15 Medications (f)
Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of medication, frequency, time, date and by whom the medication was made available to the resident.

Findings
Resident #1 physician prescribed medications *Melatonin*, *Latanoprost*, and *Timolol* not documented on March medication administration record (MAR) on 03/04/2016 – 03/10/2016.

In the future, medication logs shall be signed once said drug(s) has been dispensed and taken by the resident. A secondary care giver shall also review the medication log on a nightly basis with the dispensing care giver, furthermore a full medication administration record (MAR) review shall be held whenever a drug change has occurred by resident's prescriber(s). A final review of the residents MAR, prior to DOH annual review, shall occur with nurse case managers on a semiannual audit of residents drugs to assure that care givers are following with prescribers listing and usage of prescribed drug(s).

11-100.1-15 Medications(m)
All medications and supplements, such as vitamins, minerals, and formulas when taken by the resident shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver.

Findings
Resident #1 discontinued medications Docusate Sodium and Tylenol listed on March medication administration record (MAR) but discontinued on 01/11/2016.

Upon completion of annual 2016 DOH (Department of Health) review of care home, primary care giver (PSG) and secondary care giver (SCG) reviewed MAR in question and all other resident MAR's and completed MAR updates as of 04/01/2016. MARs which were found to be in error, medications discontinued by prescriber(s), were lined out in patient MAR (medication administration record) and dated on MAR and monthly resident progress notes of stop dates of medications or changes to their drug listing. Furthermore, the MAR in question was reviewed by nurse case manager of resident #1, and MAR was brought up to date. Docusate Sodium was lined out from dates 01/11/2016 to present and finally deleted from MAR listing following April 1st, 2016. In the future, any medication change(s) shall reflect the prescriber(s) orders and shall be dated on a secondary personal calendar of for historical purposes for the PCG and SCG. A computerized calendar monitoring of each resident after a prescriber(s) visit, shall flag a review date of a residents changed MAR and shall be corrected no later than 10 working days from a prescriber(s) change. This extra step between PCG and SCH is to assure that drugs dispensed are to prescriber(s) edited drug order(s). Both PCG and SCG shall update MAR listing to resident(s) whenever a prescriber(s) adds or changes residents medication administration record (MAR) or drug listing and follow the DOH (Department of Health) medication administration record form example in completing resident MAR's.

11.100.1-17 Records and Reports.(b)(3)
During residence, records shall include:

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;

Findings
Resident #1 missing monthly progress notes from September 2015 through February 2016.

Calendars which are interconnected via computer, tablet, smartphone and etc., shall flag and remind Primary Care Giver (PCG) and Secondary Care Giver(s) (SCGs) to properly complete progress notes for all residents and include extra progress notes flagging for expanded care residents, who require minimally 2 progress notes per month. Upon completion of 2016 annual DOH visit, progress notes were revisited and we completed as of 04/01/2016. In the future, progress notes shall be written or typed on a monthly basis. Progress notes shall be completed by either PCG or SCG in a timely manner but not to exceed 10 working days for care home residents. Expanded Care Residents progress notes shall be completed no more than 15 working days and must minimally include 2 progress notes monthly. An end of month review of progress notes shall be flagged via computer, thereby allowing primary care giver and secondary care giver appropriate time to review monthly progress notes of all residents in a timely manner. These flag dates shall be grouped into quarterly reviews or every 3 to 4 months to allow all notes to be properly entered in to progress notes. Whenever possible expanded care residents shall have their case managers review their progress notes not only to have said note critiqued but to verify to nurse case managers that PCG and SCG are properly following DOH rules for residents monthly progress note(s).