Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: **Imelda G. Arreola (ARCH/Expanded ARCH)**	**CHAPTER 100.1**
Address: **87-164 Kaukamana Street, Waianae, Hawaii 96792**	**Inspection Date: April 7, 2016 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§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, no documentation of response to Acetaminophen 500mg, two tablets made available 9/12/15.	See attached POC	5/24/16
☒	§11-100.1-17 Records and reports. (b)(8) During residence, records shall include: Notation of visits and consultations made to resident by other professional personnel as requested by the resident or the		

	Rules (Criteria)	Plan of Correction	Completion Date
	resident's physician or APRN; **FINDINGS** Resident#1, no documentation of physician office visits on 10/28/15, and 1/15/16.	See attached POC	5/24/16
☒	§11-100.1-20 Resident health care standards. (c) The primary and substitute care giver shall be able to recognize, record, and report to the resident's physician or APRN significant changes in the resident's health status including, but not limited to, convulsions, fever, sudden weakness, persistent or recurring headaches, voice changes, coughing, shortness of breath, changes in behavior, swelling limbs, abnormal bleeding, or persistent or recurring pain. **FINDINGS** Resident #1, no documentation of four (4) pound weight gain between 8/15 and 9/15. Resident#1, no documentation of four (4) pound weight gain between 1/16 and 2/16.	See attached POC	5/24/16

Licensee's/Administrator's Signature: Imelda Arreola RN

Print Name: Imelda ARREOLA

Date: 4-29-2016

Licensee's/Administrator's Signature: Imelda Arreola

Print Name: Imelda ARREOLA RN

Date: 5-24-16

PLAN OF CORRECTION (POC)

Imelda G. Arreola

Imelda G. Arreola (ARCH/Expanded ARCH)
Inspection Date: April 7, 2016
May 24, 2016

RESPONSE AND PLAN OF CORRECTION:

1. FINDINGS: Resident #1, no documentation of response to Acetaminophen 500mg, two tablets made available 9/12/15.

   POC: Whenever a Caregiver is administering medications; they will need to provide a detailed response of the Resident's behavior after the medication is received. If the Resident refuses the medication, the Caregiver will also need to document this. This will be done on a daily basis. Caregivers will be given a journal to record the Resident's behavior. In this journal, the Caregivers will document date, time, any side effects, behavioral response, refusal of medications, improvement, concerns, and any or all action taken. Logging the Resident's name, Caregiver name, and Caregiver initial is required for each entry. Documentation will be completed immediately after administration or when any incident occurs regarding medication. To remind Caregivers to record medication intake and to document their response, a checklist will be attached to the journal as to what information to provide when giving medications.

   Checklist Example:
   1. Administer medication to the Resident (check name tag and label on medication to confirm that it is the correct Resident). Make certain that the medication is given at the prescribed time and dosage.
   2. Confirm that medication is received (If Resident refuses medications, record this response).
   3. Record response with information such as date, time, any side effects, behavioral response, refusal of medications, improvement, concerns, and any or all action taken into the journal. Documentation will be completed immediately after administration or when any incident occurs regarding medicinal intake.
   4. Print the Resident's name (the one receiving the medication), Caregiver's name (the one administering the medication), and Caregiver's initial.
   5. Do this procedure accordingly for each Resident on a daily basis each time a medication is given.

   The finding was received due to a lack of documentation. The reason behind this lack of documentation was forgetfulness. To ensure that this will not happen again, a checklist will resolve this mishap. A checklist will be attached to the journal and an additional checklist can be found on the kitchen desk near the cabinets where the medications are locked. Documentation is important because it helps Caregivers understand a Resident's behavior. Since information is logged on a daily basis, Caregivers are able to find anything out of the ordinary. Documentation is needed for the Resident's health as well as liability purposes. It is essential to record each Resident's response and this new POC will solve that.

2. FINDINGS: Resident #1, no documentation of physician office visits on 10/28/15, and 1/15/16.

   POC: Records are kept to document visits and consultations made to the Resident by other professional personnel as requested by the Resident, Resident's physician, or APRN. It's important to document this information for the health and wellbeing of the Resident. Documentation is necessary due to its transparency and accountability. The visits were not recorded for 10/28/15 and 1/15/16 because staff

members/Caregivers were not aware. There was a lack of communication from the family picking up the Resident. In order to prevent this from reoccurring, it will be required for the family to fully explain their itinerary for picking up their family member (Resident), especially if it's a trip to see a physician. The Caregiver needs to explain the importance of transparency to the Resident's family for the health and wellbeing of the Resident. To ensure proper documentation, there will be a journal log for when and where a Resident leaves. In the journal, the Resident's family needs to state their intentions, document date, time, place, and sign their name as well as print the Resident's name. The Caregiver in charge would also need to sign this journal entry, notifying that they are aware. The family member will then be given a form to properly document the details of the physician visit, what had happened, and have the physician sign off as well, stating that the Resident has visited the facility under the family member's supervision. The required form and journal entry will provide the necessary transparency to prevent this from reoccurring. In addition, proper documentation for when Residents are taken to the physician with the Caregiver have always been recorded and it will remain so. The same required information and procedure of when a family member takes a Resident out is applied to when a Caregiver takes the Resident to the physician. Documentation needs to be done every time a Resident leaves and visits a physician.

The note given to the Resident's family will require the following information:

- Name of Resident, Name of Family Member
- Date, Time Departed from Care Home
- Time Arrived at Physician Office, Time Departed Physician Office
- Location of Physician, Name of Physician
- Notes on the visit, Notes from the Physician
- Signature of Family Member
- Signature of Doctor

3. FINDINGS: Resident #1, no documentation for four (4) pound weight gain between 8/15 – 9/15 and 1/16 – 2/16.

POC: The four-pound weight gain was not recorded since it seemed inconsequential. It's important to record every detail possible of the Resident's health for their wellbeing. Documentation means transparency and accountability. To prevent this from happening in the future, all Caregivers are required to document what is stated in the following checklist. This checklist will be done on a daily basis to find any changes in the Resident's health. While referring to the checklist, the Caregiver will document accordingly and store this information in the Resident's record file. The checklist can be found near the kitchen area, on the Resident's journal, and record file to serve as a reminder for the to document. This daily documentation will be collected to show the physician on the next visit of any changes in the Resident's health. From proper documentation, the physician will be able to see if any changes should be made or additional orders. In terms of weight loss or gain, the Caregiver needs to ask the physician how much weight gain or loss would be of alarming concern. Each patient is different and the Caregiver will collect this information and add it to the checklist to notify staff members/other Caregivers. If the physician has other important concerns to keep track of, it will be added to this checklist.

Checklist Example:

- Date and Time
- Are there any significant changes in health? YES/NO Explain.
- Convulsions? YES/NO
- Fever? (Provide temperature) YES/NO
- Sudden Weakness? YES/NO

- Are there persistent or recurring headaches? YES/NO
- Voice changes? YES/NO
- Coughing? YES/NO
- Is there shortness of breath? YES/NO
- Are there changes in behavior? YES/NO
- Swelling of limbs? YES/NO
- Does the patient have redness in skin? YES/NO
- Abnormal bleeding? YES/NO
- Is there any persistent or recurring pain? YES/NO
- Weight change, increase or decrease? YES/NO Specify ___ loss/gain in lbs.
  IMPORTANT: As stated by Physician #1, Resident #1 should not lose or gain ___ lbs. If the stated amount is loss/gained, please notify the Primary Caregiver and Physician immediately.
- Are there any other alarming concerns? YES/NO
- Other Notes
- Signature of Caregiver