

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: KeAloha Care Home, Inc.	CHAPTER 100.1
Address: 3617 Puuku Mauka Drive, Honolulu, Hawaii 96818	Inspection Date: January 20, 2016 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<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><b>FINDINGS</b> Resident #1 – "Acetaminophen (APAP) ER 625 mg Take 2 tabs po every 6 hours prn" ordered on 12/1/15, 9/1/15, 6/1/15 and 3/15/15; however, the medication records reflected "1-2 tabs."  Resident #1 – "Lovastatin 20 mg Tale 1 tab po at HS" ordered 12/1/15. The medication label noted "Take with a meal;" however, the medication record reflected the medication is taken at 8 p.m. Dinner is served at 5:30 p.m.</p>	<p>In moving forward, I will ensure that all resident medication orders are thoroughly checked over to make sure that they are current &amp; match exactly how the physician has ordered it to be followed. I will make sure that it is equally &amp; accurately reflected on resident MARs, quarterly physician orders &amp; all corresponding documents. I will also pay closer attention to medication labels to ensure that if there is any note of a medication needing to be taken with food or further precaution, that it is first clarified by the physician &amp; then accurately mandated into the residents care regimen.</p>	01/30/16

\*please see attached

2/1/2016

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11-100.1-15 (e) Medications. Concluding Annual Inspection in 2015 an appointment with Resident #1 Primary Care Physician was made post inspection to confirm Physician Order for Acetaminophen APAP ER 625mg and Lovatatin 20mg. All current Medication Records were checked for accuracy to reflect Physicians Orders clarified that day. To prevent similar deficiency from recurring we have streamlined our Policy & Procedure to train all current and new KeAloha Care Team Staff with a step-by-step guide to ensuring that medication label and medication record reflect the Physician Order:

1. All Medications and supplements such as vitamins, minerals, and formulas documented on Physicians Order are immediately added to Resident Medication Administration Record (MAR).
2. Any discrepancy on Pharmacy Label that does not match Physician Order is immediately brought to the attention of Pharmacy Staff and Ordering Physician. Medication and Supplements shall be made available as ordered by the Physician or APRN.
3. Changes to Physicians Order based on physician contact after original order was made, pharmacy availability, change in prescription formulary or pharmacist labeled drug use recommendations are documented immediately by Phone Order/Fax Order to Physician and filed in Resident Binder under Physician Orders section. Medication Administration Record (MAR) is revised immediately to accurately reflect any changes.
4. Inspection of all Mail Ordered, Delivered and Received Medication and Supplements is made immediately upon receipt to care home personnel and discrepancies are addressed and documented on Physician Orders and with use of Narrative Notes to document details of conversation with Physician or APRN.
5. All questions or concerns regarding Medication and Supplements will be brought swiftly to the attention of the Primary Care Giver

<input checked="" type="checkbox"/>	<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</p>	<p>(see next box)</p>	
	<p>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><b>FINDINGS</b> Resident #1 – No documentation of the need for and response to “Allegra 180 mg BID as needed” ordered 1/14/16 and taken by the resident 1-2 times a day.</p> <p>Resident #1 – Progress notes did not reflect observations of the biopsy suture site 12/3/15.</p>	<p>I will ensure that anytime a physician orders medications or implements a care plan, that there is adequate documentation of the resident's need for &amp; response to the order. Therefore, if there is any form of wound on a resident, that adequate documentation is maintained until wound has been fully healed &amp; should reflect any corresponding follow-up.</p>	<p>01/30/16</p>



§11-100.1-17 Records and reports. (f)(1)

General rules regarding records:

All entries in the resident's record shall be written in black ink, or typewritten, shall be legible, dated, and signed by the individual making the entry;

**FINDINGS**

Resident #1 – Progress notes were not signed by the individual making the entry 10/20/15 and 10/23/15.

*in moving forward with adequate documentation, I will ensure that all resident documentation is signed off by the individual making the note as is mandated by chapter 11-100 law.*

*01/30/16*

11-100.1-17(f) (1) and f(4) Records and Reports. We have implemented a consistent and thorough Binder Check in our KeAloha Care Home policy and procedure To ensure that progress notes are both complete and signed off which will prevent similar deficiencies from recurring the following steps have been put into place:

1. All KeAloha Care Team Staff is to properly adhere to all entries in Resident's Records been written in black ink or typewritten, legible, dated and signed by the team member making the entry. All Progress

Notes and Narrative Notes are to be completed at time of entry and dated, signed and filed immediately in appropriate Resident Record.

2. Any documentation such as Progress Notes, Narrative Notes, Incident Reports etc. is to be completed at the time of occurrence and shall be accurate, current and readily available for review by the department or responsible agency by filing it immediately in Resident Binder under appropriately labeled section.
3. Daily each Resident Binder is reviewed to ensure that documentation for that day was properly signed and dated. Weekly Staff Meeting's are held to discuss and review proper protocol for all KeAloha Care Home Staff and Care Team Members.
4. Written and Verbal warnings are documented between PCG/Care Home Operator and any team members whom are complacent in thoroughly documenting any entries to the mandatory standards set forth in Step 1.

<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (f)(4)  General rules regarding records:</p> <p>All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency.</p> <p><b>FINDINGS</b></p>	<p>I will ensure that any &amp; all documentation made regarding residents' care will not be left incomplete.</p>	<p>01/30/16</p>	
	<p>Resident #1 – Incomplete progress notes 1/12/16, 4/10/15 and 11/17/15.</p>	<p>* please see attached</p>	<p>1/31/2016</p>	



§11-100.1-20 Resident health care standards. (a)  
 The primary and substitute care giver shall provide health care within the realm of the primary or substitute care giver's capabilities for the resident as prescribed by a physician or APRN.

**FINDINGS**

Resident #1 – No physician order for blood sugar checks performed three (3) times a week.

I will ensure that anytime a physician orders medications, glucose checks, etc that those orders are kept as current as physician has them ordered. I will ensure that if there is any physician order that has been in effect from a previous year, is adequately documented & appropriately carried on to a current physician order for the time that it is still in standing.

01/30/16

11-100.1-20(a) Resident health care standards. To correct this deficiency Resident #1 Primary Care Physician signed off on current Physician Orders for overseeing resident's glucose checks which physician has now ordered to be done once a week. The Physicians Orders were immediately implemented in the Resident Medication Administration Record (MAR) and all KeAloha Care Team Staff were updated accordingly. To ensure that current orders for blood sugar checks are in place the following steps were initiated and implemented by KeAloha Care Team:

1. Current orders for blood sugar checks to be signed off with parameters given by Physician and kept in Physician Orders section of Resident Record.
2. Immediately update and implement Physician Order on Medication Administration Record (MAR) to be documented properly by KeAloha Care Team.
3. Consolidate and Confirm ALL Medications, Supplements and Orders such as monitoring blood glucose on Resident's Quarterly Physician Order to ensure current orders are maintained with accuracy as signed off by Primary Care Physician.



§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 that the physician was made aware of a 14 lb. weight gain January 2015 to December 2015.

moving forward, I will ensure that anytime there is a fluctuation in resident weight of, equal to or greater than 5lbs in any given month or over a period of time, that residents' physician is made aware of immediately. Follow-up with physician will be accompanied by adequate documentation if any parameters are set or need to be.

01/30/16

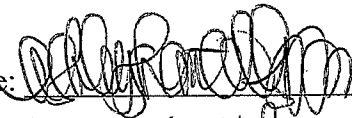
11-100.1-20(c) Resident health care standards. To correct this deficiency Resident #1 Primary Care Physician signed off on Physician Order that he was okay with overall 2015 weight gain and will have KeAloha Care Team continue to monitor once a month as usual. Primary Care Physician also tracks Resident #1 weight for his records at each appointment.

We also contacted Annette A. Jackson, our Department of Health Nutrition Consultant whom was able to confirm that she reviewed Resident #1 Special Diet : 2200 Diabetic Calorie Heart Healthy Diet which was created by his Registered Dietician assigned him at In Control Diabetes Center. Annette was pleased with his current special diet. We also implemented continued education this 2016 year by KeAloha Care Team through the Comprehensive Diabetes and Weight Management Program at Straub by advocating for additional support services from primary care physician.

To ensure that significant changes in weight gain or weight loss is identified and reported to the physician we will not only adhere to a plus and minus of five pounds in a given month but also look at a quarterly average so that physician may sign off to acknowledge any reports of weight gain or loss using the steps below:

1. Take Resident every month unless physician has ordered more frequent weight to be taken.
2. Document weight under Height / Weight section of Resident Records in binder.
3. Document weight under Height / Weight section of ARCH Binder.
4. Any weight gain or loss of 5 pounds or greater bring to immediate attention of PCG and Primary Care Physician.
5. Document Physician Orders in regards to weight and keep in Resident Record. PCG to inform all Care Team Staff of any changes that Physician Orders have indicated.
6. Document conversation with physician on the Narrative Notes and keep in Resident Record.

Licensee's/Administrator's Signature:



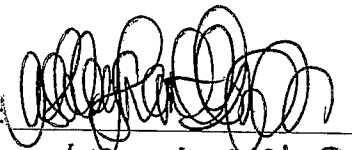
Print Name:

ASHLEY-CHANTEL GUZMAN

Date:

03/02/16

Licensee's/Administrator's Signature:



Print Name:

ASHLEY-CHANTEL GUZMAN

Date:

5/31/2016