Office of Health Care Assurance

**State Licensing Section**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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| **Facility's Name: Amodo, Marcelina (ARCH)** | **CHAPTER 100.1** |
| **Address:**<br>**1719 Perry Street, Honolulu, Hawaii 96819** | **Inspection Date: February 1, 2016 Annual** |

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-15 Medications. (b)<br>Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.<br><br>**FINDINGS**<br>Neosporin ointment unsecured in first aid kit. | See attached | 4-1-16 |
| ☒ | §11-100.1-15 Medications. (e)<br>All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.<br><br>**FINDINGS**<br>Resident #1 physician order for Omeprazole 40 mg QD before meals, medication administration record reflects medication made available at 7 a.m. and primary care giver said she serves breakfast at 7 a.m. | See attached | 4-1-16 |

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-15 Medications. (l)<br>There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.<br><br>**FINDINGS**<br>Neosporin ointment in first aid kit expired 2/12. | See Attached | 4-1-16 |
| ☒ | §11-100.1-17 Records and reports. (b)(3)<br>During residence, records shall include:<br><br>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;<br><br>**FINDINGS**<br>Resident #1 admission to Kuakini Medical Center 4/1/15, no progress note to detail circumstances of admission. | See Attached | 4-1-16 |
| ☒ | §11-100.1-17 Records and reports. (b)(8)<br>During residence, records shall include:<br><br>Notation of visits and consultations made to resident by other professional personnel as requested by the resident or the resident's physician or APRN;<br><br>**FINDINGS**<br>Resident #1 No progress notes for physician office visits on 4/10/15, 5/27/15, 6/24/15, 6/28/15, 10/2/15, 11/31/15, 12/4/15, 12/5/15, 1/7/16, and 1/20/16. | See Attached | 4-1-16 |

| | Rules (Criteria) | Plan of Correction | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-17 Records and reports. (f)(1)<br>General rules regarding records:<br><br>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;<br><br>**FINDINGS**<br>Blue ink used on 1/8/16 smoke detector log. | See attached | 4-1-2016 |

Licensee's/Administrator's Signature: Marcelina Amodo

Print Name: MARCELINA AMODO Marcelina Amodo

Date: 4-4-2016

Licensee's/Administrator's Signature: Marcelina Amodo

Print Name: Marcelina Amodo

Date: 5/21/16

**Medications. (b) 11-100.1-15**
I took out the Neosporin ointment from my first aid kit.

In the future I will not put any type of medicines or creams in my first aid kit.

**Medications. (e) 11-100.1-15**
I changed the time on my medication administration record to 6:30am to show that medication was taken before breakfast which is served at 7a.m. and reflects doctors orders of Omeprazole 40mg QD before meals.

In the future I will double check to see that I had written in my times of administration correctly and that it reflects the doctors orders.

**Medications. (l) 11-100.1-15**
I disposed of the expired Neosporin ointment in the first aid kit by opening it up and putting it in a plastic bag and mixed in a little dirt and hid it in a non see through container and threw it in the garbage can.

In the future I will do a monthly check of my first aid kit and make sure nothing is expired.

**Records and reports. (b)(3) 11-100.1-17**
I've written up an incident report for my resident's admission to Kuakini Hospital, so I used that to write up a progress note for the circumstances of admission and put it in Resident #1 folder.

In the future I will make sure to write up a progress note as well as incident reports for my resident's hospital admission as soon as I get home from the hospital. I will also write a follow up progress note to state my observations of my resident's state from the time he was admitted compared to a few days after he has been released.

**Records and reports. (b)(8) 11-100.1-17**
I wrote up progress notes for physician office visits that were missing and put them in Resident #1 folder.

In the future I will remember to write up a progress note after every doctor visit or consultation my resident goes to.

Arnoda, Marcelina

# Plan of Correction Starting 5/21/16

## 11-100.1-17(b)(8) Step by Step Plan

1. I will invest in a planner for my purse and additional calendars for the house.

2. I will write down all of my resident's appointments on both my planner and the calendars.

3. I will check my planner on a daily basis to see if there are any upcoming appointments for my residents. I will also be sure to glance over additional calendars around the house as another form of reminder.

4. The night prior to an appointment I will pull the designated binder for my resident whom has an appointment. I will gather Physician/APRN Record Form, Narrative Notes Form, and Progress Report Forms, as well as other needed forms, and place them in the front pocket of the binder. I will place the binder next to my purse.

5. At the doctor's office, I will get all necessary forms signed. I will write down any notes that I may forget in the back of my Progress Note Forms. I'll place all the forms back in the front pocket of the binder.

6. After getting home from the appointment, I will go over all paperwork. I'll file the Physician/APRN Record Form, Narrative Notes Form, etc. into it's right place in the binder. I will then fill out my Progress Note Form and indicate the happenings and anything new or changes that the physician/APRN indicated. Ill be sure to add notes I've written down on the back if necessary. If a follow up Progress Note needs to be written (ex: new medication), I will put the first Progress Note in the front pocket and add an additional blank form. I will write down in my planner as well as the calendars on a date 2 or 3 days ahead to write up a follow up progress note.

7. On day 2 or 3 after the appointment, I will write up a follow up Progress Note indicating any observations I have of my resident on the new medication, or his/her progress on a cold, etc. I will then file both progress notes in it's right place.

*****I have written up this plan of action on May 21, 2016 and will follow this procedure from here on out.*****

5/21/16

**Records and Reports (f)(l) 11-100.1-17**

John Piper the fire inspector was the one who signed and wrote with the blue pen. I was unaware that he was using a blue pen. I made a xerox copy and attached it to the original so that it would be in black in my records.

In the future, I will remind and make sure the fire inspector uses a black pen to write and sign with otherwise I will provide one for them.