Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Guerrero, Miriam (ARCH)	**CHAPTER 100.1**
Address: **66 Kaiwiki Road, Hilo, Hawaii 96720**	**Inspection Date: February 18, 2016 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. **FINDINGS** Substitute care giver (SCG) #1, no current annual physical examination. (Last done 12/03/14).	SCG NO. 1 has an appointment for P.E on March 20/16 Future Plan – Reminded her to have P.E done 2 to 3 months prior to expiration date & put on her cell phone to remind herself as well	
☒	§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** SCG #1, no current tuberculosis (TB) attestation. (Last done 12/03/14).	SCG1 – has seen Dr. Paylor on May 13, 2016 for her P.E. & TB attestation, originally she was positive on skin test & chest x-ray was negative, however doctor recommended for a chest x-ray & upon completion a copy will be filed on caregiver's folder available for inspection Future plan – put on her cellphone the date of expiration on her P.E. as well as TB attestations be done at the same time, 3 months	

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☒	§11-100.1-13 Nutrition. (b) Menus shall be written at least one week in advance, revised periodically, dated, and followed. If cycle menus are used, there shall be a minimum of four weekly menus. **FINDINGS** Resident #1, initial physical examination of March 27, 2015 read, "renal diet." However, no renal diet menu available for review.	I called Ms. Annette Jackson & she requested that I send a copy of my regular diet menu w/ guidelines for Liberty Dialysis for foods that he can & cannot eat. However I made a four week menu for renal diet that is available for review. Future Plan - put a note on the refrigerator that 4-week menus be available before admitting the patient ready for inspection	
☒	§11-100.1-13 Nutrition. (d) Current menus shall be posted in the kitchen and in a conspicuous place in the dining area for the residents and department to review. **FINDINGS** No menu posted in resident dining area for resident review.	one week menu was posted on resident's dining area on the day after the inspection Future Plan - Post a note on the refrigerator that menu for that week is posted on resident's dining area	
☒	§11-100.1-14 Food sanitation. (c) Refrigerators shall be equipped with an appropriate thermometer and temperature shall be maintained at 45°F or lower. **FINDINGS** Refrigerator thermometer read 18°F and 42°F at room temperature.	Future plan - thermometer was replaced put a reminder posted on the refrigerator to check thermometer as often as possible that it working.	

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☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** 1) Resident #1, admission medication orders dated March 20, 2015, read, "Zemplar 2 mcg PO daily, Sevelamer Carbonate (Renvela) 1,600 mg PO three times a day, Sitagliptin Phosphate (Januvia) 25 mg PO daily, Trazadone HCl 50 mg PO at bedtime." However, medications were not listed on the March – August 2015 medication records. 2) Resident #1, the June 2015 medication record reflected, "Zinc 50 g, 1 QD," administered beginning June 23, 2015. However, no physician order obtained until September 14, 2015. 3) Resident #1, physician order dated September 14, 2015 read, "Hydrocodone/Acetaminophen 5-325 mg 1-2 each PO Q4° PRN." However, the medication was not available. 4) Resident #1, medication bin contained, "Rena-Vite Rx tablet take 1 tablet by mouth once a day." However, no physician order.	A advanced medication sheet was handed to me by her daughter on an emergency placement. Future plan - record all medications that is on discharge list, w Future plan - medications on telephone order must be signed by physician as soon as possible. - Future plan - Since admission he hasn't taken the hydrocodone-acetaminophen I placed it in a locked cabinet. Future plan - See doctor on April 1st. Let doctor signed if any medication through tel, order will be signed as soon as possible, Future Plan - No. 2. Put a note highlighted posted in medicine cabinet that any medication ordered through telephone be documented right away, w/ name of resident, medication, date ordered ready to be signed by physician on the next office visit. properly No. 3 - medication was signed & now it's w/ resident's container! or box & documented on MAR & be on record. Future Plan - Post a highlighted note on medicine cabinet that all medications of resident be on container box & will not be removed. No. 4 Renavite w/c was a telephone order was documented on physician's notes & signed on April 2016 office visit. Future plan - Mark on calender that all tel. orders be documented, med:(name) date of order ready to be signed by physician on the next office visit.	

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☒	§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 order dated April 9, 2015 read, "Miralax PRN, Start Furosemide 80 mg BID for swelling." However, the medication orders were not listed on the April – August 2015 medication records.	Future Plan - any prescribed medication be on the MAR. after every office visit check physician's record & document right away & double check by comparing again the physician's & medication record to make sure it's correct. Put on cellphone alarm	
☒	§11-100.1-15 Medications. (h) All telephone and verbal orders for medication shall be recorded immediately on the physician's order sheet and written confirmation shall be obtained at the next physicians visit and not later than four months from the date of the verbal order for the medication. **FINDINGS** Resident #1, telephone order dated September 8, 2015 read, "D/C Calcium." However, no physician signature obtained.	Has physician Dr. V. Tan signed the DC of calcium on April 20/16 bec. she missed or forget to sign. Future Plan - Put on my things to do on cellphone specifically a note on going to doctor's visits, that before leaving the clinic double check if physician's notes or orders is signed & dated	

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	written confirmation shall be obtained at the next physicians visit and not later than four months from the date of the verbal order for the medication. **FINDINGS** Resident #1, telephone order dated September 8, 2015 read, "D/C Calcium." However, no physician signature obtained.		
☒	§11-100.1-17 Records and reports. (a)(1) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Documentation of primary care giver's assessment of resident upon admission; **FINDINGS** Resident #1, admitted on March 27, 2015, no admission assessment.	admission assessment done future plan - always check on admission checklist before admitting a new resident. Put on reminder list	
☒	§11-100.1-17 Records and reports. (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident #1, admitted on March 27, 2015, two (2) step TB	Resident was admitted on emergency placement & was reminded to take two step skintest but refuse to do it until October when he saw Dr. Payler who encouraged him to do it. future plan - it's on the checklist that two step skintest be done prior to admission if emergency placement make sure that it's done as early as possible,	

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	skin test completed on October 7, 2015.		
☒	§11-100.1-17 Records and reports. (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** Permanent general register thinned.	Future Plan - Put on reminder list that permanent general register shall not be thinned. I will keep everything	

Licensee's/Administrator's Signature: Miriam S. Guerrero

Print Name: MIRIAM S. GUERRERO

Date: 3/14/16

Licensee's/Administrator's Signature: Miriam S. Guerrero

Print Name: MIRIAM S. GUERRERO

Date: May 29/16