

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Baptista, Myrna (ARCH)	CHAPTER 100.1
Address: 28-2845 Makahana Street, Pepeekeo, Hawaii 96783	Inspection Date: January 13, 2016 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-8 <u>Primary care giver qualifications.</u> (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall:</p> <p>Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current;</p> <p>FINDINGS Primary care giver completed five (5) of the required six (6) hours of continuing education hours for the 2016 annual inspection year.</p>	<p><i>Attended and completed 1 credit of in service training. I want to make sure to have a completed of educational training each year as required. A self study workbook is hands on to read that reflects information and guidelines- Will submit certificate at the HCA office 6-28-2016</i></p>	<i>6-27-2016</i>
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (b)</p>	<p><i>I will write and make notes post it on the refrigerator door where its visible that reminds me everyday when its due for another training and have enough time to find places that offers training in the community. every four months of continuing education so that I am ahead of six credits.</i></p>	<i>7-15-2016</i>

	Rules (Criteria)	Plan of Correction	Completion Date
	<p>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.</p> <p>FINDINGS Menus not available and not followed.</p>	<p>menus are now written and used 4 cycle of weekly menus. In the future, I want to make sure menus are available</p>	<p>2-5-2016</p>
		<p>In the future I will post menu on the residents' dining table and on the refrigerator. And when I want to revised menu, I will contact health care assurance nutritionist for assistance.</p>	<p>7-15-2016</p>
<p><input checked="" type="checkbox"/></p>	<p>§11-100.1-13 <u>Nutrition</u> (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.</p> <p>FINDINGS No menu posted in resident dining area or kitchen.</p>	<p>menus are now posted in the resident's dining area. In the future, I want to make sure that menus are posted visible for residents to read + know what each meal is served.</p>	<p>2-5-2016</p>
		<p>I posted in the kitchen. Each menu is numbered and write in a calendar to rotate each week.</p>	<p>7-15-2016</p>

<input checked="" type="checkbox"/>	<p>§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.</p>	<p>Residents #1 All medications are updated and corrected at time of visit to physician. I want to make sure it is written and corrected as instructed as ordered.</p>	<p>1-25-2016</p>
<p>FINDINGS</p>	<ol style="list-style-type: none"> 1) Resident #1, physician order dated June 2, 2015 read, "Haldol 10 mg <u>ONE TAB</u> 3xday for 2 months." However, the June 2015 medication record read, "Haloperidol 10 mg 2 tabs TID" and "Haloperidol 10 mg TID." 2) Resident #1, physician order dated December 21, 2015 read, "Haldol 10 mg 2 tabs in am." However, December 2015 medication record read, "Haloperidol 10 mg TID" and "Haloperidol 2 tabs in am." 3) Resident #1, physician order dated June 2, 2015 read, "D/C Artane, Wellbutrin." However, Artane and Wellbutrin was not discontinued on the June 2015 	<ol style="list-style-type: none"> 1. In the future anytime there's changes on medications - my substitute will help double check medication record on physician's orders. 2. I will ask my substitute to double check medication orders and change immediately on medication sheet record. 3. In the future I will make sure to go over physician's order immediately soon after office visit and make changes on medication sheet record. 	<p>7-15-2016</p>
<ol style="list-style-type: none"> 4) Resident #1, physician order dated July 29, 2015 read, "Gabapentin 100 mg 1 capsule <u>3x</u> day." However, July 2015 - November 2015 medication records read "Gabapentin 100 mg <u>qhs</u>." 5) Resident #1, physician order dated December 21, 2015 read, "Gabapentin 100 mg 2 tabs in am 2 tabs at noon and 1 tab qhs." However, December 2015 medication record read, "Gabapentin 100 mg TID. 	<ol style="list-style-type: none"> 4. I will make sure to check as soon as I come home from office visit to check physician's order & change orders on medication sheet record and make substitute to double check. 5. I will make sure to check changes physician's record immediately soon after office visit and ask substitute to double check. 	<p>7-15-2016</p>	

<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p>FINDINGS Resident #1, medication records for March 2015 – January 2016, all medications not initialed as administered.</p>	<p>Resident #1 All medications are recorded on the medication sheet. In the future I want to make sure all residents medications are recorded as administered.</p>	<p>1-30-2016</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p>FINDINGS Resident #1, medication records for March 2015 – January 2016, all medications not initialed as administered.</p>	<p>I initialed immediately after my nurse consultant left that day. In the future I will make sure to clip board each resident's current medication record sheet each time medication is given, initialed right away and will file it in the residents' folder.</p>	<p>7-15-2016</p>
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(3) 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:</p> <p>Documentation of date of referral and admission, referral agency with address and telephone number, place or source from which admitted, physician, APRN, dentist, ophthalmologist, optometrist, psychiatrist, and all other medical or social service professionals who are currently treating the resident, next of kin, legal guardian, surrogate or other legally responsible agency;</p>	<p>In the future, I will make sure that every office visit and there's changes I will update current medications record ordered by physician immediately.</p> <p>Emergency information sheet of medication list is now updated and current. I want to make sure all emergency info is available to professionals treating residents</p>	<p>7-15-2016</p> <p>1-30-2016</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<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 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>FINDINGS Resident #1, no progress notes for February 2015 – January 2016.</p>	<p><i>I will make sure to record and documented for unusual behavior immediately as recognized. In the future I will document progress notes on the first day of each month documenting prior month.</i></p>	<p><i>7-15-2016</i></p>
		<p><i>Progress notes is now written - I want to make sure it's all documented as often as any indication of behavior changes and how they response to all residents daily living</i></p>	<p><i>1-30-2016</i></p>

<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary.</p> <p>FINDINGS Resident #1, emergency room note dated June 1, 2015 read, "you were seen today for: Palpitations, Anxiety, Paranoid Disorder." However, no incident report.</p>	<p>I will write incident report what action was taken on the progress notes + incident report. I will document it immediately after the incident occurred.</p>	<p>7-15-2016</p>	
		<p>Unusual incidents are now recorded in the progress notes. I want to make sure all are recorded and documented for future reference.</p>	<p>1-30-2016</p>	
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (h)(1) Miscellaneous records:</p> <p>A permanent general register shall be maintained to record all admissions and discharges of residents;</p> <p>FINDINGS Permanent general register thinned.</p>	<p>Permanent register is now maintained and thinned out - All old records is kept out and stored in a safe place for future used in case its needed.</p>	<p>2-26-2016</p>	
<input checked="" type="checkbox"/>	<p>§11-100.1-21 <u>Residents' and primary care givers' rights and responsibilities.</u> (a)(1)(A) Residents' rights and responsibilities:</p> <p>Written policies regarding the rights and responsibilities of residents during the stay in the Type I ARCH shall be established and a copy shall be provided to the resident and the resident's family, legal guardian, surrogate, sponsoring agency or representative payee, and to the public upon request. The Type I ARCH policies and procedures shall provide that each individual admitted shall:</p> <p>Be fully informed orally or in writing, prior to or at the time of admission, of these rights and of all rules governing resident conduct. There shall be documentation signed by the resident that this procedure has been carried out;</p> <p>FINDINGS Resident #1, no general operational policy.</p>	<p>Resident #1 A statement of Acknowledgement was signed 5-2-07 on the general operational policy for ARCH. I want to make sure all documents are made available at all times</p>	<p>6-28-2016</p>	
		<p>In the future I will review the residents folders and use admission check list to make sure all required documents are all signed and proper folder + available.</p>	<p>7-15-2016</p>	

§11-100.1-23 Physical environment. (o)(3)(B)
 Bedrooms:
 Bedroom furnishings:
 Each bed shall be supplied with a comfortable mattress cover, a pillow, pliable plastic pillow protector, pillow case, and an upper and lower sheet. A sheet blanket may be substituted for the top sheet when requested by the resident;
FINDINGS
 No pliable plastic pillow protectors on all resident pillows.

Bedroom furnishings has been cleared. discussed with resident that other belongings be stored away from resident's room. Residents in compliance with the situation. 1-26-2016

Pliable plastic pillow protectors is now supplied. I want to make sure residents will take into consideration that its necessary to put pillow protectors and if it is substituted as necessary as per request. 1-29-2016

In the future I will make sure to provide pillows for the residents write initials & resident's name to identify the owner and then write on their inventory personal list. 7-15-2016

§11-100.1-23 Physical environment. (r)
 Facilities shall be maintained in accordance with provisions of state and local zoning, building, fire safety and health codes.
FINDINGS
 Canned goods and bottled water stored on stairway.

I moved canned goods on the shelf. In the future I will make sure my to educate my substitute caregivers & household members to store canned goods food items & bottled water on shelf off the floor six inches

7-15-2016

Licensee's/Administrator's Signature: Myrna Baptista
 Print Name: MYRNA BAPTISTA
 Date: 7-15-2016

Canned goods are now stored away from the stairway for safety and health codes. I want to make sure that all canned goods are in a safe place to meet all codes and maintained.

1-29-2016

Licensee's/Administrator's Signature: Myrna Baptista
 Print Name: Myrna Baptista
 Date: 6-28-2016