Office of Health Care Assurance

State Licensing Section

RECEIVED

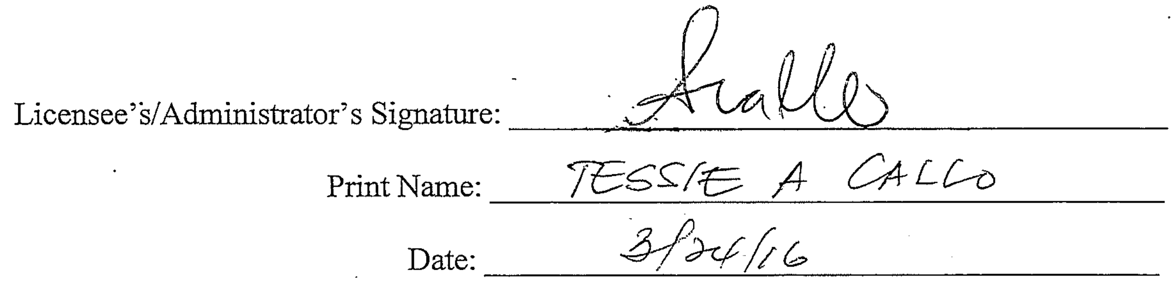
'16 MAR 30 P1:33

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Callo Care Home	CHAPTER 100.1
Address: 1027A Lowell Place, Honolulu, Hawaii 96817	Inspection Date: January 13, 2016 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§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** Resident #1 physician ordered medication, Tylenol; not made available to resident.	Resident #1 has Tylenol, however, I removed it from her medicine box because it has already expired. The family was informed but they did not bother to respond because she was not experiencing any fever. To avoid the same problem in the future, all medications ordered by the physician including PRN medications should be made available all the time. Replacement medications were made available on 1/16/16.	4/22/16
☒	§11-100.1-15 Medications. (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. **FINDINGS** Resident #1 no medications documented as administered on 1/13/16 medication administration record (MAR).	Regarding the medications documentation, I usually document after lunch when it is less busy on the day I administer the medication because mornings are quite busy. To avoid the same problem in the future, I will make sure that each time I administer the medications to the residents I will make time to document right away	1/13/16

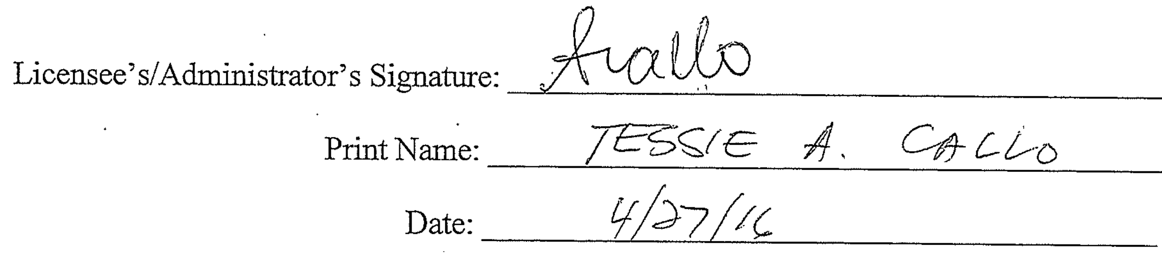
☒	§11-100.1-17 Records and reports. (a)(1) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Documentation of primary care giver's assessment of resident upon admission; **FINDINGS** Resident #1 no admission assessment for 3/17/15 admission.	When Resident #1 was first admitted on 8/16/14, I already had an admission assessment. When she was discharged from the hospital on 3/17/15, I did not do a re-admission assessment because I was not aware that she needed another admission assessment. In the future, when I admit or readmit a resident, I need to refer to the admission checklist to avoid the same problem. Admission assessment was done on 1/16/16.	4/22/16
☒	§11-100.1-17 Records and reports. (f)(4) General rules regarding records: All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency. **FINDINGS** Resident #1 binder states admission date of 8/16/14, (Resident was discharged from hospital on 3/17/15).	August 16, 2014 was the first admission date of Resident #1. When I admitted her back from the hospital on 3/17/15, I did not put the date in the binder. In the future when I admit or re-admit a resident, I will make sure to refer to the Admission Checklist so that I do not miss anything that needs to be documented and to prevent this from happening again. The re-admission date was entered in the binder on 1/16/16.	4/22/16



Licensee's/Administrator's Signature: ____________

Print Name: TESSIE A CALLO

Date: 3/24/16



Licensee's/Administrator's Signature: ____________

Print Name: TESSIE A. CALLO

Date: 4/27/16