

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

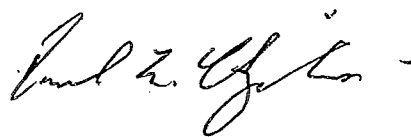
Facility's Name: Captain Cook Care Home	CHAPTER 100.1
Address: 81-1993 Haku Nui Road, Captain Cook, Hawaii 96704	Inspection Date: March 4, 2016 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications. (e)</u> All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><b><u>FINDINGS</u></b> Resident #1, physician order dated October 16, 2015 read:</p> <ul style="list-style-type: none"> <li>• "Constipation (If no stool by day 2-3, then milk of magnesia 30 cc or dulcolax tablets. If ground flax seed or sennakot not working, then step up to miralax)."</li> <li>• "Sennakot 1-2 Tabs once or twice daily as needed."</li> <li>• "Ground flax seed 1-2 Tblspoon per day-daily."</li> </ul> <p>However, medications and instructions were not listed on the October 2015 – January 2016 monthly medication records.</p>	<i>See Attached</i>	<i>2/08/2016</i>
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications. (m)</u> 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</p>	<i>See Attached</i>	<i>3/08/2016</i>

	Rules (Criteria)	Plan of Correction	Completion Date
	<p>drug, and dosage initialed by the care giver.</p> <p><b>FINDINGS</b> Resident #1, all medications not initialed as administered on August 31, 2015.</p>	<p><i>See Attached</i></p>	<p><i>3/08/2016</i></p>
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports</u>, (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:</p> <p>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;</p> <p><b>FINDINGS</b> Resident #1, admitted on August 12, 2015, no two (2) step tuberculosis (TB) skin test. (One (1) step TB skin test completed on 07-30-15).</p>	<p><i>See Attached</i></p>	<p><i>3/08/2016</i></p>
<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><b>FINDINGS</b></p>	<p><i>See Attached</i></p>	<p><i>3/08/2016</i></p>

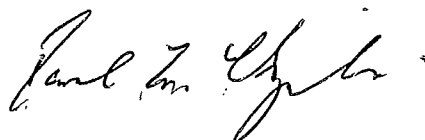
11-100.1-15 Medications. (c)

In the future, the medication and instructions will be written immediately on the Medical Flow Sheet when the physician order is received for a resident.



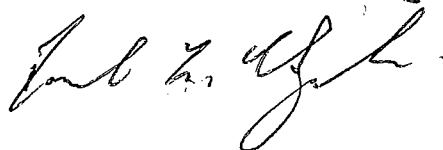
11-100.1-15 Medications. (m)

In the future, when giving medication, I will initial on the medical flow sheet the day/date the medicine is administered to the resident.



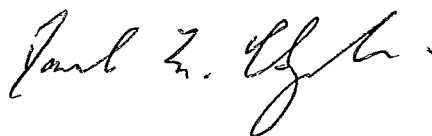
11-100.1-17 Records and reports. (a) (4)

- a. I will take the resident to her doctor on 02/15/2016 to have her two (2) Step Tuberculosis skin test.
- b. In the future, I will make sure that prior to admitting resident that the resident will complete the step #1 and step #2 Tuberculosis clearance. *AND WILL NOT ADMIT THE RESIDENT AND WILL RECEIVE THE T.B. CLEARANCE.*



11-100.1-17 Records and reports.(b) (3)

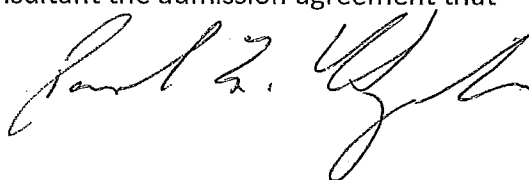
In the future, I will document in the progress note when resident refuses to take medication and will include observations of behavior with the date, time and any action taken.



11-100.1-21 Residents' and primary care giver's rights and responsibilities, (a)-(1)-(C)

A separate admission agreement was signed by the resident's family and PCG dated August 1, 2015 and filed in a separate binder with the agreed upon rate of monthly services prior to admission.

In the future, I will show and/or provide to the nurse consultant the admission agreement that was filed in a separate binder.



	Rules (Criteria)	Plan of Correction	Completion Date
	Resident #1, September 2015 medication record reflected that the resident refused Mirtazapine 15 mg on September 24 & 28, 2015. However, no documentation in progress notes.	See Attached	2/02/2014
<input checked="" type="checkbox"/>	<p>§11-100.1-21 <u>Residents' and primary care givers' rights and responsibilities.</u> (a)(1)(C) 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 and in writing, prior to or at the time of admission, and during stay, of services available in or through the Type I ARCH and of related charges, including any charges for services not covered by the Type I ARCH's basic per diem rate;</p> <p><u>FINDINGS</u> Resident #1, no rate for services listed on signed, general operational policy.</p>	See Attached	2/02/2014

Licensee's/Administrator's Signature: \_\_\_\_\_

*[Handwritten Signature]*

Licensee's/Administrator's Signature: \_\_\_\_\_

*[Handwritten Signature]*

Print Name: \_\_\_\_\_

*[Handwritten Name]*

Date: \_\_\_\_\_

*[Handwritten Date]*

Print Name: \_\_\_\_\_

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