

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| | |
|--|--|
| Facility's Name: Duldulao, Carina (ARCH) | CHAPTER 100.1 |
| Address: 417 Ekehene Place, Hilo, Hawaii 96720 | Inspection Date: September 21, 2016 Annual |

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

| | Rules (Criteria) | Plan of Correction | Completion Date |
|-------------------------------------|---|---|-----------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications</u>. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1, October 2015 medication record read, "Amciclovir 500 mg Take 1 tablet by mouth twice daily for 7 days." However, no physician order.</p> | <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>I cannot correct anymore it is too long</i></p> | <p><i>9/26/16</i></p> |

| | Rules (Criteria) | Plan of Correction | Completion Date |
|--|-------------------------|---|-----------------|
| | RULE # §11-100.1-15 (e) | <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>In the future I'll make sure to read the physician notes form that the medicine is ordered (Order) before I leaving the Dr. office. If its not listed then I ask^{ask} the Dr (ask) for prescription -</p> | 9/26/16 |

| | Rules (Criteria) | Plan of Correction | Completion Date |
|-------------------------------------|---|--|--|
| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications.</u> (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year.</p> <p><u>FINDINGS</u> Resident #1, the following medications were not reevaluated by a physician or APRN every four (4) months:</p> <ul style="list-style-type: none"> • "Levothyroxine 100 mcg," last reevaluated April 19, 2016 • "Anastrozole 1 mg," not reevaluated between October 20, 2015 – April 19, 2016 • "Invega 3 mg," not reevaluated between September 25, 2015 – April 19, 2016 | <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I can still correct I cannot correct now I cannot correct now I call the Dr. and I did the T.O. order I will let the Dr sign it. next cppt.</p> | <p>9/26/16 9/26/16 9/26/16</p> |

| Rules (Criteria) | Plan of Correction | Completion Date |
|-------------------------|--|-----------------|
| RULE # §11-100.1-15 (g) | <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>In the future the day before the office visit I will write all medications on the physician order form and have my substitute caregiver review to make sure all medications are listed for Dr review.</p> | 9/26/16 |

| | 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><u>FINDINGS</u> Resident #1, October 2015 medication record reflected "Amciclovir 500 mg take 1 tablet by mouth twice daily for 7 days." However, no reason for administration or response to medication documented on October 2015 monthly progress note.</p> | <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>I cannot already correct</i></p> | <p><i>9/26/16</i></p> |

| Rules (Criteria) | Plan of Correction | Completion Date |
|----------------------------|--|-----------------|
| RULE # §11-100.1-17 (b)(3) | <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>In the future I will document in my progress notes as soon as you start the new medication and when completed</p> | 9/26/14 |

Licensee's/Administrator's Signature: Corina J. Duldulao

Print Name: Corina J. Duldulao

Date: 9/26/16