Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Palolo Chinese Home	**CHAPTER 100.1**
Address: **2459 10th Avenue, Honolulu, Hawaii 96816**	**Inspection Date: February 3 & 4, 2016 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: 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; **FINDINGS** Resident #1 – Progress notes did not include observations of the resident's response to 1,400-2,000 ml fluids per day. Resident #3 – Physician notes reflected "coughs post prandially" on 12/7/15 and "noted to have coughing after meal" on 11/18/15; progress notes did not reflect monitoring for coughing following meals.	11-100.1-17 Records and reports. (b) (3) 1. Resident # 3 On 2.10.16 resident # 3 was assessed by the licensed nurse for "coughs post prandially" and documented that resident was noted to have an occasional non-productive cough with and after meals as if resident was trying to clear his throat. There were no difficulty in swallowing or choking noted. On 2.10.16 a Speech Therapy evaluation and treat was ordered by the physician. The resident's care plan (2.26.16) was updated to include the following interventions, which is to cue resident to: 1. To slow down his rate of eating and allow enough time to swallow his food.2.Take small bites of food.3.Swallow strong.4. Stop eating and drinking for 1 minute if cough occurs. Resident was listed on "alert charting" for ongoing observation and documentation.	2.26.16

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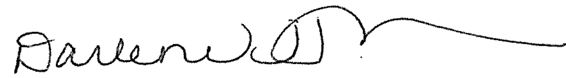
	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-88 Case management qualifications and services. (c)(2) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident; **FINDINGS** Resident #1 – Nutrition care plan did not include measurable goals for weight. Resident #2 – "Dysphagia" care plan intervention did not indicate if medications are crushed. Resident #2 – "Alteration in Elimination: At Risk for Constipation" care plan intervention reflected "Have resident exercise/walk once as tolerated, encourage mobility."	11-100.1-88 Case Management qualifications and services (c) (2) 1. On 2.17.16 resident #1 and #2's care plan was reviewed and revised by the case manager to include a measurable goal weight. On 2.17.16 resident #2's "Dysphagia" care plan was revised to include that the "resident's medication is to be crushed". The resident #2's care plan "Alteration in Elimination" was revised to include wheelchair exercises and the "Have resident exercise/walk once as tolerate, encourage mobility" was discontinued as the resident was wheelchair dependent. The resident's "At Risk for Falls" care plan was corrected and "close supervision at all times when ambulating" was discontinued as the resident was unable to ambulate. These revisions were done by the case manager on 2.17.16. On 2.17.16 the licensed nurse/case manager reviewed and updated all other care plans to ensure that it was accurate and complete, i.e. measurable weight goals, indicating when medications needed to be crushed, and appropriate interventions to prevent constipation and falls. 2. On 2.11.16 the licensed nurses were inserviced to ensure that expanded ARCH resident care plans were reviewed and updated to include "specific interventions required to meet the expanded ARCH needs" by the case managers.	2.17.16 2.17.16 2.17.16 2.17.16 2.11.16

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-88 Case management qualifications and services. (c)(2) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident; **FINDINGS** Resident #1 – Nutrition care plan did not include measurable goals for weight. Resident #2 – "Dysphagia" care plan intervention did not indicate if medications are crushed. Resident #2 – "Alteration in Elimination: At Risk for Constipation" care plan intervention reflected "Have resident exercise/walk once as tolerated, encourage mobility."	Continued from Page 2 On 2.18.16 the policy and procedure on "Medication Policy" was updated and licensed nurses inserviced to include that a physician order is obtained and transcribed onto the Medication Administration Record on crushing medications. This intervention is to be indicated on the "Dysphagia" care plan by the Case Manager as per the "Case Management qualifications and services" policy and procedure. On 2.24.16 the "Case Management Qualifications and Services" policy and procedure was established to indicate a measurable weight goal, interventions to crush medications, and interventions that are current and appropriate to meet the expanded ARCH resident's needs on the Case Manager's care plan. On 2.25.16 all nursing staff and dietitian was inserviced on the policy and procedure. On 2.17.16 the Case Managers were directed to include a measurable weight goal on each of their nutrition care plans; indicate whether medications required to be crushed on their dysphagia care plan; keep care plans (Elimination and Falls) current and updated to include "specific interventions required to meet the expanded ARCH resident's needs". The DON/Designee will audit the resident's care plan to include a measurable weight goal on each of their nutrition care plans;	2.18.16 2.24.16 3.17.16

	Rules (Criteria)	Plan of Correction	Completion Date
	Specific intervention(s) were not identified. The resident requires extensive assistance of one person with mobility, transfers, dressing, toileting and is wheelchair dependent for mobility. Resident #2 – "At Risk for Falls" care plan intervention noted "assist with FWW," "close supervision at all times when ambulating;" however, resident is wheelchair dependent for mobility. Resident #2 – Nutrition care plan did not include measurable goals for weight.	Continued from page 2 A indicate whether medications required to be crushed on their dysphagia care plan; keep care plans (Elimination and Falls) current and updated to include "specific interventions required to meet the expanded ARCH needs" by the Case Manager. Completion date: 3.17.16	

Licensee's/Administrator's Signature: 

Print Name: Darlene H. Nakayama, RN, Certified Care Home Operator

Date: 03/22/16