Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: JML	**CHAPTER 100.1**
Address: **92-560 Pilipono Street, Kapolei, Hawaii 96707**	**Inspection Date: September 24, 2015 Annual**

	Rules (Criteria)	**Plan of Correction**	**Completion Date**
☒	§11-100.1-12 Emergency care of residents and disaster preparedness. (a)(1) The licensee shall maintain written procedures to follow in an emergency which shall include provisions for the following: Arranging for immediate transfer or evaluation by a physician for any resident who becomes acutely ill, injured, or dies; **FINDINGS** Resident #1, readmitted 3/26/15; emergency sheet not current: 1. No diet update 2. No medication update 3. No mobility update	In the future; if a resident is readmitted, a new Emergency sheet shall be made with all the new information or changes. Everything should be updated. A new Emergency Information sheet was made and updated resident's diet, medications, and mobility.	09/24/2015
☒	§11-100.1-15 Medications. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled		

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	container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. **FINDINGS** Resident #1, unsecured at bedside, one (1) tube "Neosporin".	In the future, All medications should be properly labeled and stored in the medicine cabinet- locked and segregated according to use- external or internal use. Neosporin tube was placed inside locked medicine cabinet.	09/24/2015
☒	§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, no clarification obtained for one (1) signed order listing three (3) antibiotic creams. Transcribed the following incorrectly to medication record; "Neosporin or Polysporin or Bacitracin to minor abrasions 1-2x day PRN for wound care".	In the future all medication orders should be verified c the MD to be specific to avoid multiple medications in one entry. → Verified c MD above medications; Polysporin & Bacitracin have been discontinued. Continued Neosporin PRN	10/6/2015
☒	§11-100.1-15 Medications. (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident. **FINDINGS** Resident #1, no indication of any one (1) ointment of three (3) listed for one (1) medication record entry. Medication record reads, "Neosporin or Polysporin or Bacitracin to minor abrasions 1-2x day PRN for wound care".	In the future; multiple medications order in one entry will be verified with the MD to be specific. → Medications were verified c MD & DC'd Polysporin & Bacitracin & continued Neosporin PRN	10/6/2015
☒	§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		

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	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, no documentation in the progress notes for observations of the resident need or response to ointment. PRN ointment used 03/25-31/15, 04/01-30/15, 05/01-31/15, 06/01-30/15, 07/01-31/15, 08/01-31/15, and 09/01-24/15.	In the future, every PRN medication given to a resident should have a documented observation or evaluation of the effectiveness in the progress notes. An addendum to monthly Summaries for 3/2015, 4/2015, 5/2015, 6/2015, 7/2015 and 8/2015 was done to reflect the effectiveness of the medicine and the monthly Summary for 9/2015	*9/24/2015 (for the months of 3/2015, 4/2015, 5/2015, 6/2015, 7/2015, & 8/2015) *9/30/2015 for 9/1-24, 2015
☒	§11-100.1-17 Records and reports. (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. **FINDINGS** Resident #1, one (1) incident report filed in resident record; however, reports shall be retained in the care home binder.	In the future, if an Incident report is made; it should be filed in the care home binder & not in resident's record. Incident report/reports were all filed in care home binder under Incident Report Section.	9/24/2015
☒	§11-100.1-87 Personal care services. (b) The expanded ARCH shall provide an ongoing program of recreational and social activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, psycho-social well being of each resident, and shall be documented in the care plan.		

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	FINDINGS Resident #1, activity schedule not current. Activity schedule dated 03/16/10; however, resident readmitted on 03/26/15.	In the future, if a resident is readmitted, activity schedule should be updated to reflect the readmission date to make the activity schedule current. Activity Schedule has been updated.	9/24/2015
☒	§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, care plan not current. Readmitted on 03/26/15; however, no care plan developed by the Case Manager upon readmission. Care plan dated, 03/16/10, did not address the	In the future, if an expanded resident is hospitalized & readmitted, the careplan should be reviewed and updated to address the needs of the resident. * I contacted the Case manager; visited & reviewed/updated the person's careplan to address the resident's diet, mobility, and psycho-social well being.	9/28/2015

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	following current needs: 1. Diet, diabetic cardiac-dysphagia, minced nectar 1800 ADA with safe swallow guidelines; 2. Mobility, two person support for wheelchair transfer; 3. Psycho-social well being.		

Licensee's/Administrator's Signature: _____

Print Name: MERLYNE G. LIM

Date: 08/10/2016