Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: All Hearts ARCH, L.L.C.	**CHAPTER 100.1**
Address: **5962 Kawaihau Road, Kapaa, Hawaii 96746**	**Inspection Date: January 26, 2015 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-8 Primary care giver qualifications. (a)(5) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall: Have completed ARCH teaching modules that are approved annually by the department; **FINDINGS** For Primary care giver, formerly a substitute care giver, no ARCH Modules Training.	For now, Primary Care giver is care Home operator. A substitute care giver is assigned at the care Home 24 hrs. a day, 7 days a week. (Refer to comment) In the future, to prevent a similar deficiency from recurring, CHO is also the primary care giver. Before CHO assigns a PCG, CHO to discuss with RN if assigned PCG meets the criteria as stated in the care home rules and regulations	01/26/15 9/13/16

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-15 Medications. (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container. **FINDINGS** 1. Bedroom #3 – Prescribed eye drops unsecured. 2. Refrigerator – Medications stored inside a separate box in refrigerator; however lock was not engaged.	Bedroom #3 - Prescribed eye drops placed on locked Box. Refrigerator - medications lock engaged. Care Home operator instructed resident in bedroom #3 and staff to always keep medications locked. In the future, to prevent a similar deficiency from recurring, a note will be written on the medication sheet to remind caregivers to return medication to a secure area immediately after use.	01/26/15 01/26/15

Comment: In the future to prevent deficiencies from recurring, effective May 16, 2014 Former R.N Primary Caregiver of All Heart Care Home, Inc. will be R N staff of Both All Heart Care Home Inc, and Rabaino Care Home. RN will be visiting Care Homes at least 2x/month and as needed. R N will be assisting Care Home Operator with care home operations to comply with care home rules and regulations.

	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 For Resident #1, medication administration record (MAR) dated April 2014, did not match signed orders as follows: 1. MAR reads, "Metroprolol 50 mg i tab BID" ordered on 03/31/14. However, APRN order dated 04/07/14 read, "Metroprolol 50 mg i tab BID" while a physician order dated 04/14/14 read, "Metroprolol Sucinate KL (Toprol XL) 50 mg ii tab QD." 2. MAR reads, "Fluoxetine 40 mg po i tab HS" ordered on 03/31/14. However, APRN order dated 04/07/14 read, "Fluoxetine 40 mg po i tab QD" while a physician order dated 04/14/14 read, "Fluoxetine 20 mg po ii tabs Q am." 3. MAR reads, "Provastin 40mg i QD" ordered on 04/07/14. However, APRN order dated 04/07/14 read, "Provastin 40mg i tab QD" while a physician order dated 04/14/14 read, "Provastin 20 mg i tab po QD." One (1) hand written note near the physician order read, "Clarify & corrected 04/07/14 to Provastin 40 mg." 4. Physician order dated 01/15/15 read, "Colace 100 mg i tab po QD PRN." However, the MAR read, "Colace 100 mg i cap po BID PRN."	Medication Administration record (MAR) corrected on 01/27/15 and read: Metoprolol Sucinate XL (Toprol XL) 50 mg ii tabs P.O. QD Fluoxetine 20mg ii tabs po. Q am Provastatin 20mg i tab po. QD Colace 100 mg i tab P.O. QD PRN From now on. CHO to bring chart whenever a client goes for a doctor's appointment. Whenever there is a new order or any medication changes. CHO to transcribe right away on the mar and let the staff know about the changes. Jaeneri Palmeiro	01/27/2015

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-16 Personal care services. (h) A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed. **FINDINGS** For Resident #1- no schedule of activities.	Resident #1 schedule of activities was developed on 01/26/15 and showed to consultant coordinator. In the future, to prevent similar deficiencies from recurring, admission checklist to be placed in front of resident's chart and admission nurse In the future to prevent similar deficiency from recurring, schedule of activities included on the admission checklist. Admitting nurse (staff) uses the admission checklist CNO or RN to review chart at least 3 days after admission if chart is complete or not utilizing the admission checklist	01/26/2015

	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** For Resident #1, progress notes do not consistently document the resident response to treatments and PRN medications: 1. Resident participated in seven (7) physical therapy (PT) sessions beginning in May 2014 thru August 2014. Resident responses to PT exercises noted in the April progress note; however, no resident responses to PT in May thru August progress notes. 2. Physician order dated 01/15/15 read, "Colace 100 mg i cap po QD PRN." The MAR read, "Colace 100 mg i cap BID PRN." PRN medication made available BID from 11/01/14-11/30/14; however, no documentation in progress notes describing resident responses.	Late entries documented on 01/27/2015 From now on, when doing monthly progress notes, includes observation of the resident's response to treatment or PRN meds. Guidelines developed to be included on the charting: Observations, responses to tx. especially with new orders or PRN medications. Guidelines posted on the monthly summary sheets binder also I will schedule meeting with my staff and explain all my citations. Meeting at least weekly. — Jolene Forsgren And reminders to chart all observations, responses and document in progress notes about the treatment or therapy. In the future, to prevent similar deficiency from recurring, staff will be required to have yearly documentation inservices, CHO or RN to review or check resident's chart at least monthly.	

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	responses.	CHO informed staff about deficiency regarding color ink, no signature, missing date for physician order. From now on, only black ink available for charting. Made a reminder note and posted in front of the chart to only use black ink, sign progress notes, date and sign any physician order	01/27/15
☒	§11-100.1-17 Records and reports. (f)(1) General rules regarding records: All entries in the resident's record shall be written in black ink, or typewritten, shall be legible, dated, and signed by the individual making the entry; FINDINGS For Resident #1, 1. Blue ink in progress notes date, 06/06/14. 2. Red ink in the November 2014 MAR. 3. Progress notes initialed -no signature log. 4. No date for notation to clarify physician order for the physician order dated 04/17/14.	In the future, to prevent similar deficiency from recurring, only black ink is now available for documentation. CHO or RN to review on resident's chart at least monthly.	

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☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(1)(C) Residents' rights and responsibilities: 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: 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; **FINDINGS** For Resident #1, admitted on 03/03/14, no charges for services listed in the general operational policy.	Residents #1 - Charges for services listed in the general operational policy since admission 3/31/14 Charges for services are kept on a separate binder as its always done in the past for residents privacy/confidentiality. In the future to prevent similar deficiencies from occurring, binder should be available to consultant coordinator without asking for it.	01/26/2015

Licensee/Administrator's Signature: Lalaine Rabaino

Print Name: LALAINE RABAINO

Date: 5/11/15

Licensee/Administrator's Signature: Lalaine Rabaino

Print Name: LALAINE RABAINO

Date: 9/13/16

Licensee/Administrator's Signature: Lalaine Rabaino

Print Name: LALAINE RABAINO

Date: 5/30/2017