Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: **Buenavista Adult Residential Care Home**	**CHAPTER 100.1**
Address: **81-2010 Haku Nui Road, Captain Cook, Hawaii 96704**	**Inspection Date: September 22, 2017 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
☒	§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, physician order dated July 11, 2017 read, "Preser Vision Eye Vitamin one pill three times a day." However, the July – August 2017 medication records read, "Preser Vision Eye Vit. 1 cap PO BID."	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	11/5/2017

	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** Resident #1, physician order dated July 11, 2017 read, "Preser Vision Eye Vitamin one pill **three** times a day." However, the July – August 2017 medication records read, "Preser Vision Eye Vit. 1 cap PO **BID**."	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** = In the future, I will double check and see to it the right medication, right dosage and right time of all the medicines that prescribed by the Doctor befor loggin into the medical record	11/5/2017

	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 Resident #1, physician order dated January 30, 2017 read, "Metolazone 1.25 mg QOD." However, the February – April 2017 medication records read, "Metolazone 2.5 mg ½ tab PO QD."	PART 1 **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	11/5/2017

	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** Resident #1, physician order dated January 30, 2017 read, "Metolazone 1.25 mg **QOD**." However, the February – April 2017 medication records read, "Metolazone 2.5 mg ½ tab PO **QD**."	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** = In the futures I will double check the right medicine, the right dose or amount, the right route + the right time of all the the medicine that prescribed by the Doctor before loggin into the medical record. → 12/4/2017	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§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, July 2017 medication record – "Losartan 100 mg 1 tab PO QD" not initialed as administered July 20 – 31.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	11/5/2017

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§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, July 2017 medication record – "Losartan 100 mg 1 tab PO QD" not initialed as administered July 20 – 31.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** = In the future I will use a post it as a reminder, paste on the medication record. I will check medication administration record before the beginning of the month and double check for accuracy. I will initial the medication record while I am administering the the medicine and double check for accuracy. ⟶ 12/4/2017	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-15 Medications. (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications. **FINDINGS** Resident #1, medication bin contained Vitamin B12 1000 mg – Expiration date "Mar 2017."	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, I disposed the expired Vit. and get a new one	11/5/2017

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-15 Medications. (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications. **FINDINGS** Resident #1, medication bin contained Vitamin B12 1000 mg – Expiration date "Mar 2017."	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** -In the future I will double check the date and year before giving medications to the client. Dispose all expired and discontinued medicines in the proper disposal. →	12/4/2017

	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, August 2017 monthly progress note did not document the response to the following new medications prescribed on August 28, 2017: • "Senakot S 1 PO BID" • "Carbidopa-Levodopa 10-100 1 tab PO TID"	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	11/5/2017

	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, August 2017 monthly progress note did not document the response to the following new medications prescribed on August 28, 2017: • "Senakot S 1 PO BID" • "Carbidopa-Levodopa 10-100 1 tab PO TID"	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future, I will stick a note pad on the progress note record that way I will not forget to document the reactions, respond and my observations of the new medication given to the client.	11/5/2017

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§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, no progress note or incident report for the emergency department visit on August 26, 2017.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, I completed my progress note or incident report happened on that day	11/3/2017

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§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, no progress note or incident report for the emergency department visit on August 26, 2017.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future I will make sure to fill up the Incident Report completely and make a progress note when incident happened. An accurate time, day + date on it happened the incident.	→ 12/4/2017

Licensee's/Administrator's Signature: Sandy M. Buenavista

Print Name: Sandy M. Buenavista

Date: 11/10/2017

Licensee's/Administrator's Signature: Sandy M. Buenavista

Print Name: Sandy M. Buenavista

Date: 12/4/2017