Office of Health Care Assurance

**State Licensing Section**

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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| **Facility's Name: The Arc in Hawaii – Ewa A (DDDH)** | **CHAPTER 89** |
| **Address:**<br>**91-824A Hanakahi Street, Ewa Beach, Hawaii 96706** | **Inspection Date: March 14, 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 |
|---|---|---|---|
| ☒ | §11-89-14 Resident health and safety standards. (e)(3)(A)(B) Medications:<br><br>Compartments shall be provided, for each resident's medications and separated as to:<br><br>External use only;<br>Internal use only.<br><br>**FINDINGS**<br>For Resident #1, resident's external and internal medications were not separated. Resident's Bacitracin 500 units/gm Ointment was not separated from resident's oral medications, Senna-Lax and Acetaminophen. | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>The Bacitracin 500U/G Ointment was plced in a container separate from the oral medications. | March 14, 2017 |

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| | Rules (Criteria) | Plan of Correction | Completion Date |
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| ☒ | §11-89-14 Resident health and safety standards. (e)(12) Medications:<br><br>All medications and supplements, such as vitamins, minerals, and formulas, shall have written physician's orders and shall be labeled according to pharmaceutical practices for prescribed items. When taken by the resident, the date, time, name of drug, and dosage shall be recorded on the resident's medication record and initialed by the certified caregiver.<br><br>**FINDINGS**<br>For Resident #1, the October 13, 2016 medication update notes, Reguloid Powder, dissolve 1 Tablespoon in 8 oz of water orally at 8 pm, start 10/11/16; however, the October 2016 medication record noted that 1 Tablespoon was started from October 1, 2016 and that the change started on August 11, 2016. | PART 1<br><br>**Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** | |

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| ☒ | §11-89-18 Records and reports. (b)(2)<br>During residence, records shall be maintained by the caregiver and shall include the following information:<br><br>Observations of the resident's response to medication, treatments, diet, provision of care, response to activities programs, indications of illness or injury, unusual skin problems, changes in behavior patterns, noting the date, time and actions taken, if any, which shall be recorded monthly or more often as appropriate but immediately when an incident occurs;<br><br>**FINDINGS**<br>For Resident #1, on January 17, 2017, resident was newly diagnosed with Type 2 Diabetes Mellitus with Stage 3 Chronic Kidney Disease. Physician ordered to start Metformin HCL – 500 mg oral tablet, take 1 tablet orally once a day. Hold for blood sugar less than 100. There were no caregiver entries that reflected resident's new diagnosis, the start of the Metformin HCL – 500 mg oral tablet, and/or resident's response to the new medication. | PART 1<br><br>**Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** | |

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| ☒ | §11-89-18 Records and reports. (b)(5)<br>During residence, records shall be maintained by the caregiver and shall include the following information:<br><br>Physician's signed orders for diet, medications, special appliances, adaptive equipment, and treatments;<br><br>**FINDINGS**<br>For Resident #1, there was a discrepancy with resident's diet order. The January 17, 2017 medication update noted a low carbohydrate diet; however, the physical examination of that same date noted a regular diet. | PART 1<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>Clarification was made with the doctor via phone and it was confirmed that the resident had been on a low carbohydrate diet and was moved to a regular diet as noted on the physical exam form. | March 18, 2017 |

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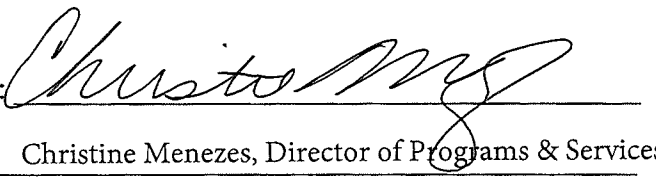
| ☒ | §11-89-18 Records and reports. (b)(5)<br>During residence, records shall be maintained by the caregiver and shall include the following information:<br><br>Physician's signed orders for diet, medications, special appliances, adaptive equipment, and treatments;<br><br>**FINDINGS**<br>For Resident #1, there was a discrepancy with resident's diet order. The January 17, 2017 medication update noted a low carbohydrate diet; however, the physical examination of that same date noted a regular diet. | **PART 2**<br><br>**FUTURE PLAN**<br><br>**USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**<br>Home manager received in service training regarding making sure that all documentation is correct and current before leaving an appointment. Corrections and clarifications should be done during the appointment and if not, in a timely manner. The Nurse will continue her quarterly audits and make written and verbal recommendations for changes and corrections. She will follow up on the corrections with the home manager and appropriate staff members within 10 days of the initial inspection. The Nursing Manager will provide oversight and conduct random quarterly audits of the client records to assure continuity as well. | March 15, 2017 |

Licensee's/Administrator's Signature: 

Print Name: Christine Menezes, Director of Programs & Services

Date: November 21, 2017