Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: JAI Adult Residential Care Home	**CHAPTER 100.1**
Address: **1719 Perry Street, Honolulu, Hawaii 96819**	**Inspection Date: November 21, 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 – Zyprexa not included on 10/16/2017 medication orders, but being administered. Per PCG, a verbal order was obtained, but there is no documentation to support this.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I took resident's most current Physician Record Sheet back to MD office to update medication list to coincide with verbal medication orders. MD wrote in Zyprexa and signed and dated it.	11/22/17

	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 – Zyprexa not included on 10/16/2017 medication orders, but being administered. Per PCG, a verbal order was obtained, but there is no documentation to support this.	**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 bring in the last copy of resident's Physician Record Sheet to compare with current Physician Record Sheet and make sure all medications are listed before leaving the office. Once a month I will have my substitute caregiver double check resident's medication list in current Physician records to make sure it is up to date.	11/24/17

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year. **FINDINGS** Resident #1 – Medication reevaluations not physically or electronically signed by the physician.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** for the After Visit Summary Sheets that did not come with an attached signed Physician Record Sheet, I had faxed it back to MD office and had MD sign it and fax it back to me.	11/02/17

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year. **FINDINGS** Resident #1 – Medication reevaluations not physically or electronically signed by the physician.	**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 always give the MD a Physician Record form that they can physically sign and attach to any After Visit Summary Sheets. In any case MD fails to use Physician Record sheet I will make sure to check that MD physically/electronically signs After Visit Sheets in location of current medication list before leaving the office. I will also have my substitute care giver check once a month that all Physican Record/ After Visit Summary sheets are signed. If any are found with no signature I will take it back to MD to get it signed or fax it to them to sign and fax back to me immediately.	11/22/17

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (e) In the event of an emergency, an oral summary of the resident's condition shall be provided to the receiving facility, followed by a written transfer summary. **FINDINGS** Resident #1 – Medications on emergency information sheet not up-to-date.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I updated all current medications on the residents Emergency Information Sheet. I also attached a copy of current Physician Record which contains updated medication list nto the Emergency Information Sheet to be used as reference and noted to see attached.	11/22/17

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (e) In the event of an emergency, an oral summary of the resident's condition shall be provided to the receiving facility, followed by a written transfer summary. **FINDINGS** Resident #1 – Medications on emergency information sheet not up-to-date.	**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, when getting home after every MD visit, I will compare resident's medication on Emergency Information Sheet to current Physician Record and update it with all new information. In addition I will attach a copy of current Physician Record to Emergency Information Sheet both in residents binder and into the extra copy I keep readily available for any emergency situation. (ex: E.R., EMT, Firemen, etc.)	11/22/17

Licensee's/Administrator's Signature: _____

Print Name: Jennifer Hawa

Date: 11/10/18