

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Malbog (DDDH)	CHAPTER 89
Address: 94-338 Apowale Street, Waipahu, Hawaii 96797	Inspection Date: May 23, 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
<input checked="" type="checkbox"/>	<p>§11-89-8 <u>Provision for services and review.</u> (d) All certified caregivers shall upgrade their skills by taking a minimum of eight hours, per year, of workshop or inservice programs approved by the division as a part of the requirement for the annual recertification.</p> <p><u>FINDINGS</u> Caregivers #1 and #2 did not meet the annual 8-hour training requirement, as not all training attended pertained to resident care. The training certificate of November 2, 2016 included training on documentation, certificate of August 3, 2016 on Prepaid Legal Aide Insurance and certificate of May 4, 2016 on Documentation Strategies. An additional 3 hours of training is needed.</p>	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>The certificates submitted, dated May 29, 2017, on Hazcom for Healthcare: A GHS Overview and Ergonomics: For Healthcare Workers now indicate Bradley Malbog and Brandon Malbog as the individuals attending the training.</p>	<p style="text-align: center;">2/26/18</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-8 <u>Provision for services and review.</u> (d) All certified caregivers shall upgrade their skills by taking a minimum of eight hours, per year, of workshop or inservice programs approved by the division as a part of the requirement for the annual recertification.</p> <p><u>FINDINGS</u> Caregivers #1 and #2 did not meet the annual 8-hour training requirement, as not all training attended pertained to resident care. The training certificate of November 2, 2016 included training on documentation, certificate of August 3, 2016 on Prepaid Legal Aide Insurance and certificate of May 4, 2016 on Documentation Strategies. An additional 3 hours of training is needed.</p>	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future, main caregiver must make sure that training sub-caregivers have taken, meets OHCA's requirements. If main caregiver is not sure, she will need to verify with OHCA.</i></p>	<p style="text-align: center;">5/29/17</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-12 <u>Structural requirements for licensure.</u> (b) Once licensed, the administrator shall be responsible for ensuring that the facility is maintained in compliance with all state and county zoning, building, fire, sanitation, housing and other codes, ordinances, and laws.</p> <p><u>FINDINGS</u> Bedroom #2 is vacant; however, is being used as storage. The closet has residents' clothing and incontinent supplies, and items such as puzzles were noted in the bedroom.</p>	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Caregivers have completely cleared bedroom #2 and is ready for occupancy.</i></p>	<p style="text-align: center;"><i>5/27/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-12 <u>Structural requirements for licensure.</u> (b) Once licensed, the administrator shall be responsible for ensuring that the facility is maintained in compliance with all state and county zoning, building, fire, sanitation, housing and other codes, ordinances, and laws.</p> <p><u>FINDINGS</u> Bedroom #2 is vacant; however, is being used as storage. The closet has residents' clothing and incontinent supplies, and items such as puzzles were noted in the bedroom.</p>	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future, all caregivers must make it a normal routine to check on a weekly basis to make sure that unoccupied but licensed bedroom must be completely empty of anything belonging to other residents or caregivers.</i></p>	<p style="text-align: center;"><i>5/21/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (d)(2) The caregiver shall develop an emergency evacuation plan to ensure rapid evacuation of the facility in the event of fire or other life-threatening situations. The plan shall be posted and shall include a provision for evacuation drills as follows:</p> <p>A written record of each drill shall be kept on file.</p> <p><u>FINDINGS</u> The fire drill reports of June 26, 2016, December 24, 2016, January 29, 2017 and February 28, 2017 did not indicate the time it took residents to evacuate from the DDDH.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (d)(2) The caregiver shall develop an emergency evacuation plan to ensure rapid evacuation of the facility in the event of fire or other life-threatening situations. The plan shall be posted and shall include a provision for evacuation drills as follows:</p> <p>A written record of each drill shall be kept on file.</p> <p><u>FINDINGS</u> The fire drill reports of June 26, 2016, December 24, 2016, January 29, 2017 and February 28, 2017 did not indicate the time it took residents to evacuate from the DDDH.</p>	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future, main caregiver must make sure that time it took residents to evacuate from the DDDH is indicated on the fire drill reports. In addition, sub-caregivers must verify the fire drill reports for accuracy and completeness prior to filing.</i></p>	<p style="text-align: right;"><i>5/29/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (d)(2) The caregiver shall develop an emergency evacuation plan to ensure rapid evacuation of the facility in the event of fire or other life-threatening situations. The plan shall be posted and shall include a provision for evacuation drills as follows:</p> <p>A written record of each drill shall be kept on file.</p> <p><u>FINDINGS</u> Resident #3 was listed on the April 29, 2017 fire drill report; however, resident was discharged from the home on November 19, 2016.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (d)(2) The caregiver shall develop an emergency evacuation plan to ensure rapid evacuation of the facility in the event of fire or other life-threatening situations. The plan shall be posted and shall include a provision for evacuation drills as follows:</p> <p>A written record of each drill shall be kept on file.</p> <p><u>FINDINGS</u> Resident #3 was listed on the April 29, 2017 fire drill report; however, resident was discharged from the home on November 19, 2016.</p>	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>Main caregiver has added "update fire drill report" to admitting a new resident check-list. In addition, main caregiver has created a discharging a resident check-list to include "update fire drill report."</i></p> <p><i>Since residents' names are pre-typed on the fire drill reports, names will be crossed out and will indicate will not participate and/or not in the DDDH.</i></p>	<p style="text-align: right;"><i>2/26/18</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (e)(4) Medications:</p> <p>All poisons shall be plainly labeled and stored separately in a locked cabinet.</p> <p><u>FINDINGS</u> Scrub Free, Comet, Hot Shot and other chemicals and/or cleaning agents were unsecured outside.</p>	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Caregiver has secured Scrub Free, Comet and other chemicals) or cleaning agents that were left outside.</i></p>	<p><i>5/23/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (e)(4) Medications:</p> <p>All poisons shall be plainly labeled and stored separately in a locked cabinet.</p> <p><u>FINDINGS</u> Scrub Free, Comet, Hot Shot and other chemicals and/or cleaning agents were unsecured outside.</p>	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future, all caregivers must always remember to secure chemicals and/or cleaning agents outside immediately after use. In addition, all caregivers must make it a normal routine to regularly be looking for any chemical and/or cleaning agents that are left unsecured when they are outside.</i></p>	<p style="text-align: right;"><i>5/23/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (e)(5) Medications:</p> <p>All medications and supplements, such as vitamins, minerals, and formulas shall be made available by written physician order and shall be based upon current evaluation of the resident's condition.</p> <p><u>FINDINGS</u> For Resident #1, on May 10, 2017, physician ordered for resident to start taking Baclofen 10 mg tablet, take 1 tab by mouth two times a day, and to continue taking Acetaminophen 325 mg tablet and Robitussin Cough-Congestion. The Q-PAP (Acetaminophen) bottle notes the strength as 500 mg and not 325 mg. Additionally, on the physician visit summaries of May 11, 2016 and March 10, 2017, the strength is also noted as 325 mg.</p>	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>main caregiver has obtained a corrected strength (500mg) of the Acetaminophen tablets from the non prescribing physician, who had mistakenly ordered the incorrect strength (325mg) on the visit summaries of May 11, 2016, March 10, 2017 and May 10, 2017.</i></p>	<p><i>3/1/18</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (e)(5) Medications:</p> <p>All medications and supplements, such as vitamins, minerals, and formulas shall be made available by written physician order and shall be based upon current evaluation of the resident's condition.</p> <p><u>FINDINGS</u> For Resident #1, on May 10, 2017, physician ordered for resident to start taking Baclofen 10 mg tablet, take 1 tab by mouth two times a day, and to continue taking Acetaminophen 325 mg tablet and Robitussin Cough-Congestion. The Q-PAP (Acetaminophen) bottle notes the strength as 500 mg and not 325 mg. Additionally, on the physician visit summaries of May 11, 2016 and March 10, 2017, the strength is also noted as 325 mg.</p>	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future, all caregivers make it a normal/routine to ensure that prescribing as well as non-prescribing physician visit summaries list of current medications must be verified against the medications strength noted on the bottle and on the medication chart for consistency after each visit. If there is any discrepancy, as in this case it's the non prescribing doctor error, it must be corrected immediately.</i></p>	<p style="text-align: right;"><i>3/1/18</i></p>

Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/> §11-89-14 <u>Resident health and safety standards.</u> (e)(12) Medications: 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. <u>FINDINGS</u> For Resident #1, the 3-month medication updates of July 21, 2016, October 21, 2016, January 21, 2017 and April 21, 2017 note, Q-PAP 500 mg (Acetaminophen 500 mg), 1-2 tabs every 4 hours PRN; however, the physician visit summaries of May 11, 2016, March 10, 2017 and May 10, 2017, instruct resident to continue taking Acetaminophen 325 mg tablets. The May 2016 – May 2017 medication records note the strength as 500 mg.	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Main caregiver has obtained a corrected strength (500 mg) of the acetaminophen tablets from the non prescribing physician, who had mistakenly ordered the incorrect strength (325 mg) on the visit summaries of May 11, 2016, March 10, 2017 and May 10, 2017.</i></p>	<p style="text-align: center;"><i>3/1/18</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 Resident health and safety standards. (e)(12) Medications:</p> <p>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.</p> <p><u>FINDINGS</u> For Resident #1, the 3-month medication updates of July 21, 2016, October 21, 2016, January 21, 2017 and April 21, 2017 note, Q-PAP 500 mg (Acetaminophen 500 mg), 1-2 tabs every 4 hours PRN; however, the physician visit summaries of May 11, 2016, March 10, 2017 and May 10, 2017, instruct resident to continue taking Acetaminophen 325 mg tablets. The May 2016 – May 2017 medication records note the strength as 500 mg.</p>	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future, all caregivers must make it a normal routine to ensure that prescribing as well as non-prescribing physician visit summaries list of medications must be verified against the strength listed on the Three-month update for consistency after office visit.</i></p>	<p><i>8/29/2017</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-16 <u>Admission policies.</u> (b)(2) The caregiver shall coordinate with the division for screening, placement, and case management prior to admission.</p> <p>All individual plans shall be monitored and revised at least annually and as necessary by the case manager.</p> <p><u>FINDINGS</u> Resident #1's Individualized Service Plan (ISP) was dated March 22, 2016. A current ISP was not on file.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Resident #1, current Individualized Service Plan, which is dated as 5/26/17, has been obtained and filed.</i></p>	<p style="text-align: right;"><i>5/26/17</i></p>

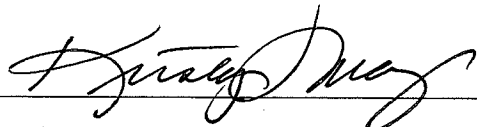
	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-16 <u>Admission policies.</u> (b)(2) The caregiver shall coordinate with the division for screening, placement, and case management prior to admission.</p> <p>All individual plans shall be monitored and revised at least annually and as necessary by the case manager.</p> <p><u>FINDINGS</u> Resident #1's Individualized Service Plan (ISP) was dated March 22, 2016. A current ISP was not on file.</p>	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future, main caregiver must make sure to receive Individualized Service Plan no later than 1 month after the ISP meeting. When the ISP meeting has been scheduled, main caregiver will set-up a reminder on her cellphone that alerts her to follow-up with case managers on the 25th day after an ISP meeting.</i></p>	<p style="text-align: center;"><i>5/26/17</i></p>


	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (a)(2) Individual records shall be maintained for each resident. Upon admission or readmission, the facility shall maintain:</p> <p>A report of a medical examination current to within nine months and current diagnosis, physician's orders for medication, diet, special appliances and equipment, treatment, evaluations or direct service to be provided by a physical therapist, occupational therapist, or speech pathologist and a report of an examination for tuberculosis performed within the year prior to admission, height and weight and medical history;</p> <p><u>FINDINGS</u> Resident #2 was admitted to the DDDH on January 1, 2017; however, the TB skin tests on file were dated January 30, 2015, February 3, 2016 and February 21, 2017. There was no verification of a two-step TB skin test being done prior to admission.</p>	<p style="text-align: center;">PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>Resident #2 has completed a 2nd TB skin test as of 5/30/17 (see enclosed copy) after admission.</i></p>	<p><i>5/30/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (a)(2) Individual records shall be maintained for each resident. Upon admission or readmission, the facility shall maintain:</p> <p>A report of a medical examination current to within nine months and current diagnosis, physician's orders for medication, diet, special appliances and equipment, treatment, evaluations or direct service to be provided by a physical therapist, occupational therapist, or speech pathologist and a report of an examination for tuberculosis performed within the year prior to admission, height and weight and medical history;</p> <p><u>FINDINGS</u> Resident #2 was admitted to the DDDH on January 1, 2017; however, the TB skin tests on file were dated January 30, 2015, February 3, 2016 and February 21, 2017. There was no verification of a two-step TB skin test being done prior to admission.</p>	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future, main caregiver must make sure that residents must have a 2-step TB skin test or TB skin test 2 years in a row prior to admission. If TB skin test is 2 years in a row, main caregiver must make sure that it's within 365 days. Main caregiver has added "TB skin test within 365 days" if TB skin test is done 2 years in a row or a single step TB skin test.</i></p>	<p style="text-align: right;"><i>5/30/17</i></p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (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 submitted to the case manager within twenty-four hours from the time of the incident and shall be retained by the facility under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician shall be called immediately if medical care is necessary.</p> <p><u>FINDINGS</u> For Resident #1, the caregiver entry of March 10, 2017 noted that resident fell backwards and landed on his buttocks in the DDDH due to a heavy backpack. Later that day, while on an outing at Pearlridge Shopping Center with the day program, resident fell backwards and hit his head on a wall. There were no incident reports available for review.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (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 submitted to the case manager within twenty-four hours from the time of the incident and shall be retained by the facility under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician shall be called immediately if medical care is necessary.</p> <p><u>FINDINGS</u> For Resident #1, the caregiver entry of March 10, 2017 noted that resident fell backwards and landed on his buttocks in the DDDH due to a heavy backpack. Later that day, while on an outing at Pearlridge Shopping Center with the day program, resident fell backwards and hit his head on a wall. There were no incident reports available for review.</p>	<p style="text-align: center;">PART 2 <u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future, whether it's a minor incident or an incident that happened outside of DDDH, main caregiver will always remember she must do an incident report. Main caregiver has posted a copy of the incident report form on the bulletin board as a reminder to always do an incident report for any incident that happens inside and outside of the DDDH.</i></p>	<p style="text-align: right;"><i>11/17/17</i></p>

Licensee's/Administrator's Signature: 
Print Name: KRISTY MALBOG
Date: 11/20/17

Licensee's/Administrator's Signature: 
Print Name: KRISTY MALBOG
Date: 3/4/18