Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: The Arc in Hawaii – Lusitana D (DDDH)	**CHAPTER 89**
Address: **1660 D Lusitana Street, Honolulu, Hawaii 96813**	**Inspection Date: November 29, 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. (d)(3) 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: Each resident of the facility shall be certified annually by a physician that the resident is capable of self-preservation. A maximum of two residents not so certified may reside in the facility provided that a staff ratio of one-to-one is maintained, at all times, for each of these residents and there are no stairways which must be negotiated by such noncertified residents. As an alternative, the facility shall install an automatic sprinkler system, as defined in the national fire protection association's 101 life safety code. **FINDINGS** For Resident #1, a Self-Preservation Statement was not on file.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Home manager faxed self preservation statement to the primary physician for correction and update.	February 15, 2018

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-89-14 Resident health and safety standards. (d)(3) 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: Each resident of the facility shall be certified annually by a physician that the resident is capable of self-preservation. A maximum of two residents not so certified may reside in the facility provided that a staff ratio of one-to-one is maintained, at all times, for each of these residents and there are no stairways which must be negotiated by such noncertified residents. As an alternative, the facility shall install an automatic sprinkler system, as defined in the national fire protection association's 101 life safety code. **FINDINGS** For Resident #1, a Self-Preservation Statement was not on file.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Home manager received in service training regarding reviewing paperwork that is sent via mail to the home by a physician's office. Home manager will review the information and will contact the physician for any corrections that are needed promptly. A copy of the paper work should be submitted to the agency nurse within 72 hours for review. It will be the responsiblity of the Nurse to return any incomplete paperwork to the Home Manager to have them complete appropriately. In addition, the nurse will continue her quarterly audits and make written recommendations for changes and corrections. She will follow up on the corrections with the home manager and appropriate staff members. The Nursing Manager will also provide oversight and conduct random quarterly audits of the client records.	November 30, 2017

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-89-14 Resident health and safety standards. (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. FINDINGS For Resident #1, the December 2016 medication administration record noted "AM"; however, did not specify the time the Levothyroxine 50 mcg tablet was given.	PART 1 **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-89-14 Resident health and safety standards. (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. **FINDINGS** For Resident #1, the December 2016 medication administration record noted "AM"; however, did not specify the time the Levothyroxine 50 mcg tablet was given.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Typical standard is for morning medication to be given in at 6:00 am. The medication record was updated to reflect the proper administration time as 6 a.m. The Home Manager will verify each medication entry on the medication record to the medication when the records arrive monthly to assure that the information is correct and will notify the Nurse of any changes that need to be made. In addition, the Home Manager will verify that the times of when the medications are given are also noted on the medication record. Entries will be verified by the Nurse within 24 hours when a new medication is started as well. The Nurse will continue her quarterly audits and make written recommendations for changes and corrections. She will follow up on the corrections with the Home Manager and appropriate staff members. The Nursing Manager will provide oversight and conduct random quarterly audits of the client records.	November 30, 2017

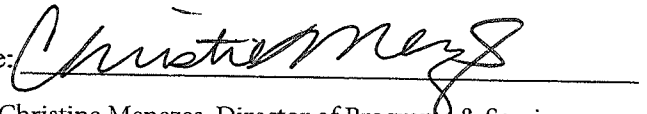
	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-89-14 Resident health and safety standards. (e)(12) Medications: All medications and supplements, such as vitamins, minerals, and formulas, shall have written physician's orders and shall be labeled according to pharmaceutical practices for prescribed 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. **FINDINGS** For Resident #1, Levothyroxine 50 mcg tablet was listed twice on the December 2016 medication administration record. One tablet to be taken at night and one tablet to be taken on an empty stomach in the morning once a day. The physician order of November 29, 2016 noted to give Levothyroxine 50 mcg tablet once daily. The night time dose was not initialed as given. Additionally, although resident's admission date on the registry was noted as December 1, 2016, medications were not initialed as given until December 27, 2016. The medication administration record did not indicate who was responsible for giving resident her medications from December 1 – 26, 2016.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Incorrect entry for Levothyroxine 50 mcg for the December was corrected to reflect a once daily dose as described in physician note on November 29, 2016.	November 30, 2017

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-89-14 Resident health and safety standards. (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. **FINDINGS** For Resident #1, Levothyroxine 50 mcg tablet was listed twice on the December 2016 medication administration record. One tablet to be taken at night and one tablet to be taken on an empty stomach in the morning once a day. The physician order of November 29, 2016 noted to give Levothyroxine 50 mcg tablet once daily. The night time dose was not initialed as given. Additionally, although resident's admission date on the registry was noted as December 1, 2016, medications were not initialed as given until December 27, 2016. The medication administration record did not indicate who was responsible for giving resident her medications from December 1 – 26, 2016.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Home staff and new Home Manager received in service training regarding correct documentation on the medication record when a resident is away from the home. Staff will mark "G" to indicate a resident is "Gone". As a new Home Manager, the Nurse trained on proper documentation practices regarding verifying medication record entries when they arrive monthly to ensure the information is correct and will notify the nurse of any changes that need to be made. Entries will be verified when a new medication is started as well. The nurse will continue her quarterly audits and make written recommendations for changes and corrections. She will follow up on the corrections with the Home Manager and appropriate staff members. The Nursing Manager will provide oversight and conduct random quarterly audits of the client records.	November 30, 2017

Licensee's/Administrator's Signature: 

Print Name: Christine Menezes, Director of Programs & Services

Date: January 31, 2018

Licensee's/Administrator's Signature: 

Print Name: Christine Menezes, Director of Programs & Services

Date: March 20, 2018