

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: C.A.R.E. Hawaii, Inc. – Emergency Shelter/Emergency Respite (STF)	CHAPTER 98
Address: 94-483 Apowale Street, Waipahu, Hawaii 96797	Inspection Date: October 13, 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>§11-98-10 <u>Minimum standards for licensure: administrative and organizational plan.</u> (e) Each facility shall develop written policies and procedures, and criteria governing its management and operations. These shall include but are not limited to the following:</p> <p><u>FINDINGS</u> For Resident #1, the facility's written policies and procedures, N10.4 Transcription of Physician Orders, were not followed, as evidenced by:</p> <ul style="list-style-type: none"> Pharmacy label of September 9, 2017 notes, Ibuprofen 600 mg tab, take 1 tab by mouth twice daily as needed for pain; however, the September and October 2017 medication administration records note, Ibuprofen (Motrin Tablet) 600 mg p.o. every 6 hours PRN, which is consistent with the physician order of July 24, 2017. 	<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>A physician order has been obtained to reflect this change. Please see attachment A.</p> <p>Also re-trained Charge Nurse on N10.4 Transcription of Physician orders. Please see attachment B.</p>	<p style="text-align: center;">3/9/18</p> <p style="text-align: center;">1/31/18</p>

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<input checked="" type="checkbox"/>	<p>§11-98-10 <u>Minimum standards for licensure: administrative and organizational plan. (e)</u> Each facility shall develop written policies and procedures, and criteria governing its management and operations. These shall include but are not limited to the following:</p> <p><u>FINDINGS</u> For Resident #1, the facility's written policies and procedures, N10.4 Transcription of Physician Orders, were not followed, as evidenced by:</p> <ul style="list-style-type: none"> Pharmacy label of September 9, 2017 notes, Ibuprofen 600 mg tab, take 1 tab by mouth twice daily as needed for pain; however, the September and October 2017 medication administration records note, Ibuprofen (Motrin Tablet) 600 mg p.o. every 6 hours PRN, which is consistent with the physician order of July 24, 2017. 	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>RN had supervision regarding transcription of physician orders P&P N10.4 on 1/31/18. Please see Attachment C.</p> <p>If label not consistent with order from physician, request new label from Pharmacy. Nurse is responsible to ensure consistency and make changes.</p>	<p>1/31/18</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-98-16 <u>Resident's rights and responsibilities.</u> (1) Written policies regarding the rights and responsibilities of residents and services to be provided to residents during their stay in the facility shall be established and shall be made available to the resident, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. The facility's policies and procedures shall provide that each individual admitted to the facility shall:</p> <p>Be fully informed, documented by signed acknowledgment prior to or at the time of admission and during stay, of these rights and of all rules governing resident conduct;</p> <p><u>FINDINGS</u> Resident #1 was admitted to the facility on July 26, 2017. Acknowledgement of receipt for the Resident's Rights and Responsibilities was not signed by the resident until August 1, 2017. The resident's Individualized Service Plan of December 16, 2016 identified an uncle as a legal co-guardian and an aunt as a temporary legal co-guardian. The CARE Hawaii, Inc. – DD Referral Service form identifies resident's aunt as the legal guardian. There was no verification that the legal guardian was informed of Resident #1's rights and responsibilities.</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 style="text-align: center;"><i>Participant no longer at program and unable to contact family member, participant discharged 12/26/17.</i></p>	<p style="text-align: center;"><i>1/31/18</i></p>

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Licensee's/Administrator's Signature: Jesse Newirth

Print Name: Jesse Newirth

Date: 2/2/18

Licensee's/Administrator's Signature: Jesse Newirth

Print Name: Jesse Newirth

Date: 3/12/18

Licensee's/Administrator's Signature: Jesse Newirth

Print Name: Jesse Newirth

Date: 6/7/18