Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: The Arc in Hawaii – Ewa A (DDDH)	CHAPTER 89
Address: 91-824A Hanakahi Street, Ewa Beach, Hawaii 96706	Inspection Date: March 6, 2018 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.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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, on September 12, 2017, physician initially ordered Loperamide HCL 2 mg Oral Capsule, take 1 capsule by mouth every 4-6 hours as needed for diarrhea; however, on the same prescription, there was an approval to change the frequency to every 6 hours prn, which is consistent with the pharmacy label of that same date. The September 2017 medication administration record; however, notes the frequency as every 4-6 hours prn.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-89-18 Records and reports. (b)(2) During residence, records shall be maintained by the caregiver and shall include the following information: 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; FINDINGS For Resident #1, an incident report, dated January 28, 2018, was written for resident's bruise on the right buttocks. The bruise was bluish purple in color. One caregiver wrote on the incident report that the bruise was the "size of a kimchee bowl," while another caregiver wrote that it was the "size of a bowl of kimchee bowl or bigger." There were no caregiver entries regarding the bruise found and/or of follow up by staff.	PART 1 **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) During residence, records shall be maintained by the caregiver and shall include the following information: 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; **FINDINGS** For Resident #1, an incident report, dated January 28, 2018, was written for resident's bruise on the right buttocks. The bruise was bluish purple in color. One caregiver wrote on the incident report that the bruise was the "size of a kimchee bowl," while another caregiver wrote that it was the "size of a bowl of kimchee bowl or bigger." There were no caregiver entries regarding the bruise found and/or of follow up by staff.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** The Director of Programs and Services met with home staff to discuss the proper protocol of documenting all significant injuries (bruising) in a resident's file. Documentation of follow up care and action taken by staff if necessary such as first aid, scheduling an appointment with primary care and resident's response to care were also discussed. An agency wide training on Incident Reports and documentation is scheduled in April 2018 which home staff will be required to attend. In addition, when an incident report is written, the home manager will review the reports and caregiver entries on quarterly basis to ensure the incident was documented in the resident's file. If the incident was not documented in the resident's file, a late caregiver entry will be inputted. The Director of Programs & Services will also review the incident reports and caregiver entries to ensure proper documentation is being completed.	April 5, 2018

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Licensee's/Administrator's Signature: [signature]

Print Name: Christine Menezes, Director of Programs & Services

Date: April 12, 2018

Licensee's/Administrator's Signature: [signature], DPS

Print Name: Christine Menezes, Director of Programs & Services

Date: May 11, 2018