

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name: Malbog (DDDH)</b>	<b>CHAPTER 89</b>
<b>Address: 94-338 Apowale Street, Waipahu, Hawaii, 96797</b>	<b>Inspection Date: May 8, 2018 Annual</b>

**THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.**

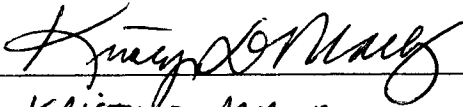
**YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**


	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (e)(3)(A)(B) Medications:</p> <p>Compartments shall be provided, for each resident's medications and separated as to:</p> <p>External use only; Internal use only.</p> <p><b><u>FINDINGS</u></b> For Resident #1, the Mupirocin Ointment USP, 2% was in the same compartment as resident's oral medications.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>Mupirocin ointment and other external use only medications have always been placed in separate compartments for each resident and all compartments have always been kept in a separate cabinet from oral medications cabinet. After the audit, Mupirocin ointment was separated from oral medications, returned in its own compartment and kept in a separate cabinet.</i></p>	<p style="text-align: center;"><i>6/17/18</i></p>

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<input checked="" type="checkbox"/>	<p>§11-89-14 Resident health and safety standards. (e)(3)(A)(B) Medications:</p> <p>Compartments shall be provided, for each resident's medications and separated as to:</p> <p>External use only; Internal use only.</p> <p><b><u>FINDINGS</u></b> For Resident #1, the Mupirocin Ointment USP, 2% was in the same compartment as resident's oral medications.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>External use only medications in separate compartment for each resident have always been kept in a separate cabinet from oral medication cabinet and must continue to be kept in a separate compartment and separate cabinet. Main caregiver has added to the checklist for annual audit: 'External use only medications and oral medications must be in separate compartments when placed on the table for audit.'</i></p>	<p>6/17/18</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards.</u> (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><b><u>FINDINGS</u></b> For Resident #1, the physician order of June 3, 2017 noted, Divalproex ER 500 mg, 1 tab every HS; however, since resident's admission on June 23, 2017, the medication record noted the dosage as 2 tabs at bedtime. It wasn't until June 27, 2017, that the physician's order was changed to 2 tabs at bedtime.</p>	<p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	

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☒	<p>§11-89-14 <u>Resident health and safety standards.</u> (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><b><u>FINDINGS</u></b> For Resident #1, the physician order of June 3, 2017 noted, Divalproex ER 500 mg, 1 tab every HS; however, since resident's admission on June 23, 2017, the medication record noted the dosage as 2 tabs at bedtime. It wasn't until June 27, 2017, that the physician's order was changed to 2 tabs at bedtime.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>Main caregiver has added to the checklist for admitting a resident: 'Most current medication order on doctor visit record prior to admission, which include the name of the medication, dosage and frequency, must be the same as the indicated medication name, dosage and frequency on the medication bottle label. Main caregiver must verify and sub-caregiver must reverify immediately when medication is delivered. Main caregiver or sub-caregiver must clarify with the pharmacy and the doctor immediately if there is any discrepancy. Correction must be made immediately when discrepancy is clarified.'</i></p>	<p style="text-align: right;"><i>6/17/18</i></p>

Licensee's/Administrator's Signature:   
Print Name: KRISTY D. MALBOG  
Date: 5/8/18

Licensee's/Administrator's Signature:   
Print Name: KRISTY MALBOG  
Date: 6/17/18

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