

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Ohana	CHAPTER 100.1
Address: 2011 Kamualii Street, Honolulu, Hawaii 96819	Inspection Date: November 14, 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>§11-100.1-15 <u>Medications</u>. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Physician’s medication order for Acetaminophen states, “500 mg, 2 tabs po 4x/day PRN pain or fever.” Medication label reads, “Acetaminophen 500 mg, take 2 tablets po every 4 hours PRN pain or fever (do not exceed 6 pills daily). Physician’s order and label do not match.</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>I brought the doctor's order to the pharmacy and the pharmacist labeled the med correctly.</i></p>	<p style="text-align: right;"><i>mgm</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Physician’s medication order for Acetaminophen states, “500 mg, 2 tabs po 4x/day PRN pain or fever.” Medication label reads, “Acetaminophen 500 mg, take 2 tablets po every 4 hours PRN pain or fever (do not exceed 6 pills daily). Physician’s order and label do not match.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><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 style="text-align: center;"><i>I will bring the doctor's order and check it to the pharmacy to make sure that the doctor's order is the same as the label on the med.</i></p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p><u>FINDINGS</u> Resident #1 – Monthly progress notes do not include observations of the resident's response to medications.</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>I included observation of the resident's response to medication when I wrote my monthly progress notes.</i></p>	<p style="text-align: right;"><i>mying</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p><u>FINDINGS</u> Resident #1 – Monthly progress notes do not include observations of the resident's response to medications.</p>	<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><i>I will let my substitute check my monthly progress note by the 30th of each month and make a checklist to remind her that progress notes has been checked and done.</i></p>	<p><i>ongoing</i></p>

Licensee's/Administrator's Signature: Carmen Dona

Print Name: CARMEN DONA

Date: 1/19/18

Licensee's/Administrator's Signature: Carmen Down

Print Name: CARMEN DOWN

Date: 3/27/18