Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: R & M Duran, L.L.C.	**CHAPTER 100.1**
Address: **94-628 Loaa Street, Waipahu, Hawaii 96797**	**Inspection Date: April 12, 2018**

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
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 - "acetaminophen 325 mg tab 2 tablets orally every 6 hours as needed' ordered 3/28/18; however, the label read "1 tab."	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I CORRECTED, BY WRITING THE EXACT DOCTORS ORDER IN THE LABEL.	4/24/18

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 - "acetaminophen 325 mg tab 2 tablets orally every 6 hours as needed' ordered 3/28/18; however, the label read "1 tab."	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I WILL CLARIFY WITH THE PCP IF PRESCRIBED MEDICATION AND OTC MEDICINE IS NOT CONSISTENT WITH THE LABEL.	6/28/18

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(1) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Documentation of primary care giver's assessment of resident upon admission; **FINDINGS** Resident #1 - No admission assessment upon readmission on 12/11/17.	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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☒	§11-100.1-17 Records and reports. (a)(1) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Documentation of primary care giver's assessment of resident upon admission; **FINDINGS** Resident #1 - No admission assessment upon readmission on 12/11/17.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I WILL MAKE A LIST OF: ADMISSION CHECK LIST EVERY TIME DURING ADMISSION OF A RESIDENT, AND RE-ADMISSION.	4/24/18

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(4) During residence, records shall include: Entries describing treatments and services rendered; **FINDINGS** Resident #1 - "1-1.5 liters/day;" fluid restriction ordered 1/22/18; however, no documentation that the fluid restriction was provided.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I CALLED THE DOH REGISTERED DIETICIAN ON HOW TO DOCUMENT FLUID RESTRICTION. I FOLLOWED WHAT THE DIETICIAN RECOMMENDS.	4/24/18

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(4) During residence, records shall include: Entries describing treatments and services rendered; **FINDINGS** Resident #1 - "1-1.5 liters/day;" fluid restriction ordered 1/22/18; however, no documentation that the fluid restriction was provided:	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I WILL CHECK WITH MY NURSE CONSULTANT, REGISTERED DIETICIAN AND CASE MANAGERS IF I NEED TO DOCUMENT DOCTOR'S ORDER THAT I RENDERED A SERVICES LIKE; DOCUMENTING MY SERVICES ON THAT PARTICULAR DOCTOR ORDER. I WILL MAKE A CHECK LIST OF WHAT TO DOCUMENT IN MY PROGRESS NOTES/MAR I WILL ALSO DOCUMENT IMMEDIATELY SERVICES RENDERED.	4/24/18

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-88 Case management qualifications and services. (c)(4) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Update the care plan as changes occur in the expanded ARCH resident care needs, services and/or interventions; **FINDINGS** Resident #1 - Service plan was not updated when changes occurred. For example: • "Renal diet, low sodium" ordered 12/11/17; however, the service plan noted "regular." • "Fluid restriction 1-1.5 liters thin liquid/day" ordered 1/22/18; however, the service plan did not address the fluid restriction. Service plan updated 2/18/18.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I ASKED THE CMRN TO UP-DATE THE SERVICE PLAN.	4/24/18

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-88 Case management qualifications and services. (c)(4) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Update the care plan as changes occur in the expanded ARCH resident care needs, services and/or interventions; **FINDINGS** Resident #1 - Service plan was not updated when changes occurred. For example: • "Renal diet, low sodium" ordered 12/11/17; however, the service plan noted "regular." • "Fluid restriction 1-1.5 liters thin liquid/day" ordered 1/22/18; however, the service plan did not address the fluid restriction. Service plan updated 2/18/18.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I WILL READ THE CARE PLAN AT LEAST ONCE A WEEK AND ANY TIME THAT THERE'S CHANGES ORDERED BY A DOCTOR. I WILL WORK WITH THE CASE MANAGER TO UPDATE THE CARE PLAN.	4/24/18

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-88 Case management qualifications and services. (c)(8) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Have face-to-face contacts with the expanded ARCH resident at least once every thirty days, with more frequent contacts based on the resident's needs and the care giver's capabilities; **FINDINGS** Resident #1 - No documentation of face-to-face contact by the case manager 2/18/18 to present.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I OBTAINED A COPY OF MONTHLY NURSING ASSESSMENT FROM THE CASE MANAGEMENT AGENCY.	4/24/18

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-88 Case management qualifications and services. (c)(8) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Have face-to-face contacts with the expanded ARCH resident at least once every thirty days, with more frequent contacts based on the resident's needs and the care giver's capabilities; **FINDINGS** Resident #1 - No documentation of face-to-face contact by the case manager 2/18/18 to present.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** ON EVERY RN/CM VISIT I WILL INFORM THAT I NEED A COPY OF THE NURSING ASSESSMENT IN ONE WEEK AFTER FACE TO FACE CONTACT. I WILL MAKE A NOTE ON THE DATE OF VISIT. I WILL CONTACT MY RN/CM IF NURSING ASSESSMENT IS NOT RECEIVED WITHIN THE SET TIME FRAME.	6/28/18

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Licensee's/Administrator's Signature: Marenila L. Duran

Print Name: MARENILA L. DURAN, CNA.

Date: 4/25/18

Licensee's/Administrator's Signature: Marenila L. Duran

Print Name: MARENILA L. DURAN

Date: 6/28/18