

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Kalakaua Gardens	CHAPTER 90
Address: 1723 Kalakaua Avenue, Honolulu, Hawaii	Inspection Date: June 19 & 20, 2018 Biennial

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) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-90-8 <u>Range of services.</u> (b)(3)(B)(i) Services.</p> <p>The assisted living facility shall have policies and procedures relating to medications to include but not be limited to:</p> <p>Administration of medication:</p> <p>Prescription and non-prescription medications which the facility has responsibility for administering to a resident must be identified in the resident's record and must be prescribed in writing for the resident by a physician or prescribing advanced practice registered nurse;</p> <p><u>FINDINGS</u></p> <p>Resident #2, physician orders dated 12/5/16 for lidocaine 5% cream and orders dated 1/9/17 for Salonpas Lidocaine patch were discontinued on the April 2017 medication administration record without any written orders from a physician or APRN.</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;">SEE ATTACHED</p>	<p style="text-align: center;">7/20/18</p>

11-90-8 (b)(3) (B)(i): A discontinuation order faxed to Resident #2's physician for review and signature on 6/20/2018. Received signed discontinuation order from physician via fax and filed in resident's chart on 6/27/2018.

 7/20/18

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11-90-8 (b)(3) (B)(i): I received a signed faxed order by the resident's MD on 6/27/18. A copy is attached. To prevent this from happening again, I will educate staff to obtain a signed order prior to discontinuing medication. Staff will date and initial when discontinue order received. The nurse will review, date and initial when completed.

[Handwritten signature] 7/20/18

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-90-8 <u>Range of services.</u> (b)(3)(B)(ii) Services.</p> <p>The assisted living facility shall have policies and procedures relating to medications to include but not be limited to:</p> <p>Administration of medication:</p> <p>The facility shall provide and implement policies and procedures which assure that all medications administered by the facility are reviewed at least once every 90 days by a registered nurse or physician, and is in compliance with applicable state laws and administrative rules.</p> <p><u>FINDINGS</u></p> <p>Resident #1 and Resident #2 no proof that the medications were reviewed by an R.N. or M.D. every 90 days.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p>7/20/18</p>

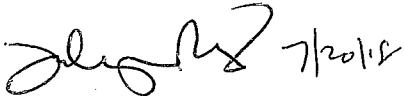
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11-90-8 (b)(3) (B)(ii): In the future, I (we) will educate staff to have the registered nurse review medications administered by the facility every 90 days when quarterly assessments are completed. The computer program that we currently use has a system that will alert when quarterly assessments are due. The nurse will update assessment and medications every 90 days and log on a Resident Medication Review sheet when completed.

Julia [unclear] 7/20/18

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
	<p>§11-90-9 <u>Record and reports system.</u> (a)(1) The facility shall establish policies and procedures to maintain a system of records and reports which shall include the following:</p> <p>Copy of a current physician or primary care provider's report of resident's physical examination which includes tuberculosis clearance and verification that the resident is free from other infectious or contagious diseases;</p> <p><u>FINDINGS</u></p> <p>Resident #3 two-step TB test completed 4 days after resident was admitted to the facility.</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;">SEE ATTACHED</p>	<p style="text-align: center;">7/20/18</p>

11-90-9(a)(1): In the future, I (we) will educate staff that both 1st and 2nd part of 2-step TB skin test needs to be completed prior to admission. Documentation will be reviewed and initialed on signed History and Physical form that is received at least three days prior to admission. Resident will not be admitted unless History and Physical form is complete.

Handwritten signature and date: 7/20/18

Licensee's/Administrator's Signature: Jenny Reyes Caday
Print Name: Jenny Reyes - Caday
Date: 6/29/18

Licensee's/Administrator's Signature: Jenny Reyes Caday
Print Name: Jenny Reyes Caday
Date: 7/20/18

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