Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Angel Home for Seniors	**CHAPTER 100.1**
Address: **1315 Kupau Street, Kailua, Hawaii 96734**	**Inspection Date: February 26, 2016 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. **FINDINGS** Substitute care giver (SCG) #2 – No physical examination prior to contact with residents. The primary care giver (PCG) and all SCGs attended a four (4) hour in-service on 9/26/15. **Submit copy with the plan of correction (POC).**	SCG#2 will no longer be use as a SCG. Prior to any SCG in contact with residents, 2-steps PPD clearance, physical examination, CPR, 1st aid will be completed and on file at all times. When attending CE classes all SCG will take turn in taking classes and to ensure that SCG meet all requirements if outside SCG are needed.	3/1/16
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** SCG #2 – No tuberculosis clearance prior to contact with residents. **Submit copy with the POC.**	SCG #2 will no longer be use as a SCG. Prior to any SCG in contact with residents a 2-step PPD clearance will be obtain and place on file at all times.	3/1/16

	Rule / Findings	Plan of Correction	Date
☒	§11-100.1-13 Nutrition. (b) Menus shall be written at least one week in advance, revised periodically, dated, and followed. If cycle menus are used, there shall be a minimum of four weekly menus. **FINDINGS** Resident #1 – No special diet menu for "minced diet" provided to the resident. The menu used was not appropriate for a "minced diet" as it contained corn, raw vegetables, peanut butter, whole grain pancakes, raisins, popped popcorn, and whole wheat crackers.	Resident #1 special diet is completed and in place. When creating a special diet for any resident or any type of diet and if doubt check with the DOH dietician for what type of food would be appropriate for type of diet, example soft, minced, pureed.	3/10/16
☒	§11-100.1-13 Nutrition. (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit. **FINDINGS** Resident #1 – "Regular, soft chopped" diet ordered on 2/22/16; however, PCG reported "minced" diet has been provided.	Resident #1 diet order obtained and clarified with APRN. Any diet changes inform MD and case manager physician orders, verbal orders, document and fill out the Physician/APRN sheet for the MD to sign on the next visit for confirmation. Case manager to include orders and up date care plan.	3/10/16
☒	§11-100.1-15 Medications. (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container. **FINDINGS** "Refresh eye drops" unsecured at a resident's bedside.	Medication secured and locked-corrected. All medications will be secured and lock as soon administered in the medicine cabinet. Re-train SCG yearly to refresh procedures.	2/24/16

☒	§11-100.1-15 Medications. (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container. **FINDINGS** "Refresh eye drops" unsecured at a resident's bedside.	Substitutes - Instructed to check for any medication @ the bedside of each resident when cleaning or providing care. PCG or Sub - will check on a daily basis for medication at the bedside.	3/9/17
☒	§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 – "Melatonin 3 mg one tab po Q HS" ordered 2/22/16; the label reflected "take ½ tab." Resident #1 – "Tamsulosin" label reflected "Take one-half hour following the same meal each day;" however, the medication record indicated that the medication is taken at 7 p.m. Dinner is served at 5:30 p.m.	Resident #1 Melatonin corrected. Tamulosin corrected. Cross check all medication orders, labels and MAR to ensure the orders are the same. Any discrepancy verify and clarify with the physician, document, obtain the right order and right medication with proper label and fill out the APRN order sheet to be sign by the MD on the next visit to confirm order. Change MAR to reflect the correct order or instruction.	2/27/16
☒	§11-100.1-16 Personal care services. (j) Resident(s) manifesting behaviors that may cause injury to self or others shall be assessed by a physician or APRN to determine least restrictive alternatives to physical restraint use, which may be used only in an emergency when necessary to protect the resident from injury to self or to others. If restraint use is determined to be required and ordered by the resident's physician or APRN, the resident and the resident's family, guardian or surrogate, and case manager shall be notified and a written consent obtained. The licensee shall maintain a written policy for restraint use outlining resident assessment processes, indications for use, monitoring and evaluation and training of licensee and substitute care givers. Renewal orders for restraint use shall be obtained on a weekly basis from the resident's physician or APRN based on the assessment, monitoring and evaluation data presented by the primary care giver. **FINDINGS** No written policy for ½ sheet (restraint) use.	Completed policy. Provide and impliment a Restraint policy for 1/2 sheet restraint to use to include: every 2 hours, check resident skin condition, release restraint to position/reposition resident for circulation to include walking, standing bed rest, offer food and water, able to insert hand freely between the resident and the restraint sheet. Monitor, assess, evaluate resident daily and document any unusual finding while asssisting resident in a restrain, notify physician, case manager for such changes and documents. Obtain regular orders as required.	3/15/16

		§11-100.1-17 Records and reports. (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary. **FINDINGS** Resident #1 – Two (2) incident reports for 9/24/15 were in the resident record.	Provide a separate folder for incident reports. completed. Do not attached with the daily documentations once completed file it right away in the incident report folder. Re-check, follow up and re-train SCG for proper procedure and perform a yearly training to ensure all SCG follow procedures.	2/20/16	
		§11-100.1-17 Records and reports. (f)(1) General rules regarding records: All entries in the resident's record shall be written in black ink, or typewritten, shall be legible, dated, and signed by the individual making the entry; **FINDINGS** Resident #1 – Blue ink used to sign the July 2015 progress notes.	Resident #1 completed no blue ink. Provide black ink only and remove all blue ink pen to ensure black ink pen is always use and black pen are always available	2/27/16	

☒	§11-100.1-23 Physical environment. (g)(3)(A) Fire prevention protection.	Plan of Correction	Completion Date
	Type I ARCHs shall be in compliance with, but not limited to, the following provisions: Fire escapes, stairways and other exit equipment shall be maintained operational and in good repair and free of obstruction; **FINDINGS** Exit through the garage was obstructed by a car. Clearance was decreased to 30 inches.	Fire exit through the garage corrected. Check and ensure all fire exits are in fully working condition at all times. No obstruction/ free and clear at least 36 inches wide at all times.	2/27/16
		Sub. instructed to check and ensure there is 36 inches clearance and the cars are not preventing the door from opening. PCG. Sub will check daily for 36 inches clearance ~~free~~ from garage exit.	3/9/7

☒	§11-100.1-83 Personnel and staffing requirements. (1) In addition to the requirements in subchapter 2 and 3:		
	A registered nurse other than the licensee or primary care giver shall train and monitor primary care givers and substitutes in providing daily personal and specialized care to residents as needed to implement their care plan; **FINDINGS** PCG and SCG #1– No documentation of training in providing daily personal and specialized care for Resident #1. PCG and all SCG – No documentation of training in use of the ½ sheet (restraint) to keep resident in chair. PCG & all SCG – No documentation of training for aspiration precautions.	PCG completed training and documented for special needs/care, 1/2 sheet restraint and aspiration precaution as well as the other SCG. SCG #1 no longer be a SCG. Will ensure all SCG are trained prior to contact to resident for any special need or care provided to the residents. Case manager will documents all training and include in the care plan.	3/31/16

☒ §11-100.1-88 Case management qualifications and services.
(c)(2)
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:

Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident;

FINDINGS
Resident #1 – The Risk for Imbalance Nutrition and Fluid Intake care plan intervention did not include:
- Regular soft chopped diet (ordered 2/22/16)
- Thicken liquids as tolerated to nectar consistency (ordered 2/22/16)
- Consistency of liquid served to the resident
- "Ensure" nutritional supplement ordered by the physician

Resident #1 – The Impaired Urinary Elimination care plan did not include the "ciprofloxacin 250 mg Take 1 tab po 2 x daily prn (symptoms of UTI) for up to 7 days" ordered by the

RESIDENT#1 Nutrition Fluid intake.
Corrected and included in the care plan.
Cipro corrected, included in the care plan.
Medication crushed corrected and included in the care plan.
Tamusolin corrected sprinkle beads over food included in the care plan.

VERIFY AND CLARIFY ALL MEDICATION USE AND INSTRUCTIONS WITH THE PHYSICIAN, OBTAIN THE RIGHT ORDER, DOCUMENT AND FILL OUT PHYSICIAN ORDER SHEET FOR THE PHYSICIAN TO SIGN ON THE NEXT VISIT FOR CONFIRMATION.

3/31/16

Notify MD and case manager for any changes in Resident conditions. If such changes in any medications or diet, order proper orders and medication labels to reflect such change then document. Notify case manager right away for any changes and to up date care plan. PCP will also up date MAR as needed.
Verify all medications with the MD for clarifications to how, when and purpose for each medications, then obtain proper orders as well as the proper label for such medication then document. Read and follow instruction from the medication bottle label and if it's given diffently from the medication bottle instruction then call MD to clarify the oder to how the medication is given, any changes obtain proper order as well as right medication label to reflect changes then document.
Once changes or new orders are receive always notify case manager for changes and to up date care plan right away as well as PCP to up date MAR right away.

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FINDINGS
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- Thicken liquids as tolerated to nectar consistency

physician 2/22/16, 12/24/15, and 11/20/15.

Resident #1 – The care plan did not include the following:

- Medications are crushed
- Plan for "tamsulosin" label that noted: "Swallow whole do not chew or crush."

Resident #1 – The Altered or At Risk for Altered Skin Integrity care plan did not include the following daily medication: Mupirocin, Baza antifungal, nystatin powder, and miconazole nitrate 2% cream.

Plan of correction	Date
Resident #1 Skin ingrety. ointment- corrected and included in the care plan. Clarify and verify with physicians for use and instruction if any question, documents and obtain physician order, fill out physician order sheet for the physician to sign on the next visit to confirm order.	3/31/16
Review all changes and up date with case managers once completed to include all staffs/caregivers and have all staffs sign a train or re-training sheet when training is completed. Follow up and review as changes occour or/and a yearly basis as needed.	9/18/16
I will read the care plan AND. ensure that Physician Orders is reflected in the care plan. AND service provided also in the care plan.	3/9/17

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

Print Name: Ancelie Cabel

Date: 4/14/16

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

Print Name: Ancelie Cabel

Date: 9/18/16

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

Print Name: Ancelie Cabel

Date: 3/8/17