

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name: Adult Res Care Home</b>	<b>CHAPTER 100.1</b>
<b>Address: 1654 Hauiki Street, Honolulu, Hawaii 96819</b>	<b>Inspection Date: March 12, 2019 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.**

19 MAR 21 10:50 AM

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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.</p> <p><b>FINDINGS</b> Substitute care giver #4, no evidence of an annual tuberculosis skin clearance.</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>TB clearance obtained, substitute went to her scheduled date for reading and the result ... A copy of TB clearance filed to care home chart.</p>	<p>3/21/2019</p>

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 19 MAR 21 11:21

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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.</p> <p><b>FINDINGS</b> Substitute care giver #4, no evidence of an annual tuberculosis skin clearance.</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>- It's a sure good idea to put it in the calendar the expiration date of the TB clearance of any TB expiration date (of my substitutes, family, and myself) so I can remember the dates when it's in the calendar. So I can remind them to go and get it. And to check it ahead of time. Maybe to write it one month before it will expire.</p>	<p style="text-align: right;">3/21/2019</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (k)  Physician or APRN orders for nutritional supplements including vitamins, minerals, formula meals and thickening agents shall be updated annually or sooner as specified.</p> <p><b>FINDINGS</b>  Resident #1, Primary Care Giver (PCG) reports, "Thick-It" added to liquids to make the liquids pudding thickened. However, no order for thickening agent available.</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>- Called PMD to change the order. It should have a thick it - an agent to thicken any liquid... Now ordered for thick it, filed to chart.</p>	<p style="text-align: right;">6/27/19</p>

19 APR 21 PM 2:25

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u> (k) Physician or APRN orders for nutritional supplements including vitamins, minerals, formula meals and thickening agents shall be updated annually or sooner as specified.</p> <p><u>FINDINGS</u> Resident #1, Primary Care Giver (PCG) reports, "Thick-It" added to liquids to make the liquids pudding thickened. However, no order for thickening agent available.</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 will make sure that before I offer a resident a thickening agent, check the order again, if the order is complete identifies the thickening agent and the thickness level. <del>And</del> And to do so I will double check the PWD's order or review the order to the MD - before leaving the MD's office.</p> <p>And for the yearly renewal I will make a note on my calendar the expiration of the order to remind me for the expiration date and to make sure it will be renewed every year or more often if needed.</p>	<p>May 9, 2019</p> <p style="text-align: right; font-size: small;">11:30 AM - 12:11 PM</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, order (3/4/19) reads, "may crush medication as appropriate," PCG reports crushing pills. However,</p> <ol style="list-style-type: none"> <li>1. No order to specify medication to crush.</li> <li>2. No documentation in the medication administration record for instructions to crush.</li> </ol>	<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>- Obtained a new order ordered can crush all tabs. except Venlafaxine ER. etc can give with pudding consistency food. New ordered, documented in the chart already (MAR) (the instruction for the crush medicines)</p>	<p>May 9, 19</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><b>FINDINGS</b> Resident #1, order (3/4/19) reads, "may crush medication as appropriate," PCG reports crushing pills. However,</p> <ol style="list-style-type: none"> <li>1. No order to specify medication to crush.</li> <li>2. No documentation in the medication administration record for instructions to crush.</li> </ol>	<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>- Upon ordering by the NP to crush medications, make sure to review the order while I'm still @ NPs office that the order should have specify all the medications to crush.</p> <p>- And after ordering the crush medications, make sure to document / write it right away so I won't forget it.</p>	<p style="text-align: right; font-size: 2em;">3/7/19</p> <p style="text-align: right; font-size: 0.8em;">19 MAR 21 11:25 AM</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(3)  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:</p> <p>Documentation of date of referral and admission, referral agency with address and telephone number, place or source from which admitted, physician, APRN, dentist, ophthalmologist, optometrist, psychiatrist, and all other medical or social service professionals who are currently treating the resident, next of kin, legal guardian, surrogate or other legally responsible agency;</p> <p><b>FINDINGS</b>  Resident #1 the "Resident Emergency Information" form is missing page two and is incomplete.</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 style="text-align: center;"><i>Corrected right away, second page completed + filed to charts and to any emergency information that was being made.</i></p>	<p style="text-align: right;"><i>3/21/19</i></p> <p style="text-align: right;">19 MAR 21 PM 2:45</p>



	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(3) 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:</p> <p>Documentation of date of referral and admission, referral agency with address and telephone number, place or source from which admitted, physician, APRN, dentist, ophthalmologist, optometrist, psychiatrist, and all other medical or social service professionals who are currently treating the resident, next of kin, legal guardian, surrogate or other legally responsible agency;</p> <p><b>FINDINGS</b> Resident #1 the "Resident Emergency Information" form is missing page two and is incomplete.</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>Everytime I have to admit a resident, double check (The Resident Emergency Information form make sure the 2 forms are complete. Make sure to complete the 2 pgs &amp; file it to chart &amp; etc. To always remember it and pay attention to it</p>	<p style="text-align: right;">May 9, 19</p> <p style="text-align: right;">19 MAY -9 AMO 1</p> <p style="text-align: right;">STATE OF MICHIGAN DEPARTMENT OF STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (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:</p> <p>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;</p> <p><b>FINDINGS</b>            Resident #1, care plan reflects POLST form is available. However, POLST form dated 1/31/19 is incomplete. Only one (1) signature by PMD listed on the form.</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 style="text-align: center;">- Corrected, patient signed &amp; filed to chart / + to any of the emergency information to go to hospital &amp; etc.</p>	<p style="text-align: right;">3/21/19</p> <p style="text-align: right;">19 MAR 21 12:45</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (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:</p> <p>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;</p> <p><b><u>FINDINGS</u></b>            Resident #1, care plan reflects POLST form is available. However, POLST form dated 1/31/19 is incomplete. Only one (1) signature by PMD listed on the form.</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>- Review the POLST carefully after, when the (family, patient + doctor) doing the POLST make sure all the signatures are to be sign by perspective person before filling to chart on to any emergency information.</p>	<p style="text-align: center;">3/21/19</p> <p style="text-align: right;">19 MAR 21 12:45 STATE CORRECTIONS</p>

Licensee's/Administrator's Signature: Delia G. Laurent

Print Name: DELIA G. LAURENT

Date: 3/21/2019

Licensee's/Administrator's Signature: Delia G. Laurent

Print Name: DELIA G. LAURENT

Date: May 9, 2019