# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Hawaii Island Recovery

CHAPTER 98

Address:
73-4697 Hina Lani Street, Kailua-Kona, Hawaii 96740

Inspection Date: October 21, 2022 - 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.

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 |
|---|---|---|
| ☒ §11-98-10 Minimum standards for licensure: administrative and organizational plan. (e)<br>Each facility shall develop written policies and procedures, and criteria governing its management and operations. These shall include but are not limited to the following<br><br>FINDINGS<br>Resident #3 physician order read, "Venlafaxine Hcl. 75 mg x 0.5 tablet extended release 24 hr, oral, tablet extended release 24 hr, once a day (AM) until further notice<br>However, the bottle was not labeled by a pharmacy and medication provided was capsules (unable to administer 0.5 of a capsule). | PART 1<br><br>DID YOU CORRECT THE DEFICIENCY?<br><br>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY<br><br>Resident #3 and Medical Director decided to continue Venlafaxine 75 mg PO capsule as received from the pharmacy and wait to taper the medication until after discharge, and under supervision from her regular PCP. Medical Director discontinued the medication order for Venlafaxine 75 mg 0.5 tablet PO Qam and wrote a physician order for 'Venlafaxine 75 mg PO capsule.' Venlafaxine 75 mg capsules were verified by the RN and MD and labeled accordingly. | 10.21.22 |

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| ☒ | §11-98-10 Minimum standards for licensure; administrative and organizational plan. (e)<br>Each facility shall develop written policies and procedures, and criteria governing its management and operations. These shall include but are not limited to the following:<br><br>**FINDINGS**<br>Resident #3 – physician order read, "Venlafaxine Hcl, 75 mg x 0.5 tablet extended release 24 hr, oral, tablet extended release 24 hr, once a day (AM) until further notice. However, the bottle was not labeled by a pharmacy and medication provided was capsules (unable to administer 0.5 of a capsule). | **PART 2**<br><br>**FUTURE PLAN**<br><br>**USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**<br><br>1. Managing Director (MD) met with Lead Patient Care Coordinator (LPCC) and Registered Nurse (RN) to ensure that all medication is checked for correct label and matching prescription before leaving the pharmacy with the medication and to ensure that the Nurse check medication for right name, medication, time and route.<br><br>2. RN perform ongoing weekly audits of all prescribed medications to ensure that the prescribed medication matches the prescription in drug, dose, route, type.<br><br>3. Pharmacist perform quarterly audits of medication control procedures at the facility ensuring correct administration and medication record as well as storage and labeling of all prescribed medication as well as over the counter medication.<br><br>4. Required training for all Resident Managers (RM) and Patient Care Coordinators (PCC) staff in Nurses Delegation and Medication Management, including medication use and inventory, and medication use practices. | 10.24.22<br><br>12.2.2022<br><br>12.19.2022 |

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| ☒ | §11-98-10 Minimum standards for licensure: administrative and organizational plan. (e)<br>Each facility shall develop written policies and procedures, and criteria governing its management and operations. These shall include but are not limited to the following:<br><br>**FINDINGS**<br>Hawaii Island Recovery "Residential Program Policies and Procedure Section Title: Medication Use did not address the storage of past/discontinued medications.<br>Resident #3 – the following medications found in the resident medication bag did not have physician orders: Scopalamine, Wixela, Aripiprazole 5 mg, Momestasone ointment, Naltrxone. | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>1. The Managing Director (MD), Lead Patient Care Coordinator (LPCC), and QA Specialist (QA) met with the state representative during the facility site visit and discussed procedures for medication control and labeling. The audit found: "Residential Program Policies and Procedure Section Title: Medication Use did not address the storage of past/discontinued medications.<br>Resident #3 - The medications in the resident's bag did not have physician orders: Scopolamine, Wixela, Aripiprazole 5 mg, Momestasone ointment, and Naltrexone.<br><br>2. State representative recommended the QA specialist update the Medication Use section to address the storage of past/discontinued medication.<br><br>3. Based on the recommendation by the state representative QA specialist added the following paragraph to the policies and procedures p. 180:<br>"i) Medication without a doctor's order such as past or discontinued medications brought by the patient into treatment must be stored in a separate labeled bag and placed in a safe storage at the facility and handed back to the patient at discharge." | 10.21.22 |

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| ☒ §11-98-11 Minimum standards for licensure: personnel. (l) The administrator shall see that at least one staff member on each shift possesses a current First Aid certificate and CPR training. Recertification of training shall be required by all staff at least every two years.<br><br>FINDINGS<br>Staff #1 cardiopulmonary resuscitation (CPR) completed on 07-11-22 via online training. Please note that CPR certification must be completed in person | PART 1<br><br>DID YOU CORRECT THE DEFICIENCY?<br><br>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY<br><br>1. Staff #1 was informed that online CPR training programs are not compliant with current state guidelines. Staff #1 was directed to complete an in-person CPR training.<br><br>2. Staff #1 completed an in person CPR training on 12/8/2022. (See attached certification) | 10.21.22<br><br>12.8.22 |

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| ☒ §11-98-12 Minimum standards for licensure: services. (2) Individual records shall be kept on each resident which contain the following:<br><br>A report of a tuberculin skin test. If the skin test is positive, or known to be positive, there shall be documentation that appropriate medical follow-up has been obtained:<br><br>FINDINGS<br>Resident #1, admitted on 09-29-22 - no tuberculosis (TB) skin test<br>Resident #2, chest x-ray dated 09-27-22 read, "r/o TB " However, no TB skin test.<br>Resident #3, admitted on 10-03-22 – no TB skin test.<br><br>This is a repeat deficiency from our 2021 annual inspection. | PART 1<br><br>DID YOU CORRECT THE DEFICIENCY?<br><br>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY<br><br>1. All patients mentioned had their TB tests scheduled immediately after the survey in order to bring the facility into full compliance.<br><br>Residents 1, 2 & 3 all received their TB skin tests on 11/27/22<br><br>Each resident had their skin test read on 11/30/22. (See attached documentation.) | 10.21.2022<br><br>11.27.2022 |

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| ☒ | §11-98-12 Minimum standards for licensure; services. (11) Individual records shall be kept on each resident which contain the following:<br><br>Height and weight, which shall be recorded, upon admission and thereafter, quarterly;<br><br>**FINDINGS**<br>Resident #2, admitted on 09-30-22 – height and weight obtained on 10-01-22. | **PART 1**<br><br>**Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** | |

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| | 1. The Managing Director (MD), Lead Patient Care Coordinator (LPCC), and QA Specialist (QA) met with the state representative during the facility site. Audit found: Resident #2, admitted on 09-30-22 - height and weight obtained on 10-01-22. | 10.21.2022 |
| | 2. The Managing Director (MD), Lead Patient Care Coordinator (LPCC), and Medical Director (MED) met and discussed best the reason for the tardiness in data entry. The reason for the tardiness was related to the change of office location for MED that resulted in the late data entry. | 10.24.2022 |
| | 3. The MED is in place at his new office location and will ensure data entry on the day of admission for height and weight to ensure ongoing compliance | |
| | 4. It was determined that the Registered Nurse will be tasked with the responsibility of ensuring that MED does, in fact, enter height/weight data upon admission. | |

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Licensee's/Administrator's Signature: _____

Print Name: NICK B. PETTET

Date: 03.31.2023

Licensee's/Administrator's Signature: James M. Kayihura

Print Name: JAMES KAYIHURA

Date: 12/6/2022