

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: CEJ Charity ARCH-EC, L.L.C.	CHAPTER 100.1
Address: 45-415 Kulauli Street, Kaneohe, Hawaii 96744	Inspection Date: July 12, 2023 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.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><u>FINDINGS</u> Substitute Care Giver (SCG) #1, SCG #2, and SCG #3 - No documented evidence of PCG training to make medications available.</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>Substitute Care Givers (SCG) #1, #2, and #3 were provided training and checked off on basic skills using the Primary and Substitute caregiver training tool including medication administration in case substitute caregiver covers for a period less than four hours. The rule of "5 rights" in administering medication and proper documentation in the Medication Administration Record (MAR) were discussed as well.</p>	<p>SCG #1 7/18/23</p> <p>SCG #2 7/18/23</p> <p>SCG #3 7/19/23</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><u>FINDINGS</u> Substitute Care Giver (SCG) #1, SCG #2, and SCG #3 - No documented evidence of PCG training to make medications available.</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>In the future, any newly hired substitute caregiver will be given training and checked off on the basic skills checklist, including medication administration to residents as prescribed and proper documentation in the MAR (Medication Administration Record) while covering for the primary caregiver.</p> <p>To ensure that newly hired SCG's receive the proper training: orientation and basic skills (as described above) shall be added in the checklist of requirements (Physical exam, TB clearance, CPR/First Aid certification) to serve as a reminder of task completed with date and initial.</p>	<p>On going upon hiring</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 – Physician order for “Nifedipine 30mg tab. Take 1 tab PO before breakfast. Hold for SBP <100.” On 3/3/23, blood pressure was recorded as 121/60 on Medication Administration Record (MAR), however, medication was documented as held (H) despite blood pressure reading being above hold parameter. No correspondence noted documenting rationale for holding medication.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	


	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	<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 – Physician order for “Nifedipine 30mg tab. Take 1 tab PO before breakfast. Hold for SBP <100.” On 3/3/23, blood pressure was recorded as 121/60 on Medication Administration Record (MAR), however, medication was documented as held (H) despite blood pressure reading being above hold parameter. No correspondence noted documenting rationale for holding medication.</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>In the future, any medication (with parameter, e.g. blood pressure) shall be given to resident as prescribed. If, for some reason, the medication is held or not given, the reason for holding (e.g. lethargy, etc.) shall be properly documented in the progress notes, as well as the action done (e.g. re-checking or notifying MD).</p> <p>As a reminder, the MAR shall be flagged with sticker for the action taken on such day, to address the issue, notify MD and document in the progress notes correspondingly. Only then shall the flag removed and marked the task completed.</p>	On-going

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (c) 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 – Physician order for “Nifedipine 30mg tab. Take 1 tab PO before breakfast. Hold for SBP <100.” MAR for 4/8/23 does not have a record of a blood pressure reading for that day, however medication was initialed as administered.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</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 – Physician order for “Nifedipine 30mg tab. Take 1 tab PO before breakfast. Hold for SBP <100.” MAR for 4/3/23 does not have a record of a blood pressure reading for that day, however medication was initialed as administered.</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>In the future, all medications with blood pressure parameter shall have the blood pressure reading recorded in the MAR (Medication Administration Record) to reference accordingly, whether to hold or give the medication as prescribed by the physician.</p> <p>To ensure that documentation is complete, required BP readings shall be written in appropriate date/time slot ASAP. As a reminder, MAR shall be reviewed for completeness every after medication administration.</p>	<p style="text-align: center;">On going</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (f)(1) General rules regarding records:</p> <p>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;</p> <p><u>FINDINGS</u> Resident #1 – Blue ink was observed in MAR on 6/13/23.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports. (f)(1)</u> General rules regarding records:</p> <p>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;</p> <p><u>FINDINGS</u> Resident #1 – Blue ink was observed in MAR on 6/13/23.</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>In the future, all documentation in the residents' chart, shall be written in black ink only. A note for such "USE BLACK INK ONLY" shall be posted in all resident binders, including the MAR (Medication Record Administration) binder, to serve as a reminder to all staff.</p>	On-going

Licensee's/Administrator's Signature: 
Print Name: Carolyn B. Lazo
Date: 8/15/23