Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Paradise ARCH	CHAPTER 100.1
Address: 86-112 Hoaha Street, Waianae, Hawaii 96792	Inspection Date: February 13, 2024 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 PER HAR 11-100.1-3(e)(2). IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

FAILURE TO CORRECT CITED DEFICIENCIES AS PER THE PLAN OF CORRECTION COULD RESULT IN REFUSAL TO RENEW YOUR LICENSE PER HAR 11-100.1-3(e)(3).

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident. **FINDINGS** Resident #1 – Physician ordered "Acetaminophen 325mg tablet, 2 tablets PO daily PRN." Medication label, medication order, and medication administration record does not reflect as needed (PRN) indication for aforementioned medication.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** yes **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** 1) Contacted and informed Resident #1's Physician that OHCA (OHCA) issued a citation for missing PRN indication. 2) Requested from the Physician that the order for PRN medication written as "Acetaminophen 325mg tablet, 2 tablets PO daily "PRN" be re written to include a PRN indication - for pain + fever 3) Contacted the Pharmacy and requested that the medication label include a PRN indication for pain + fever on the next refill	2/23/24

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident. **<u>FINDINGS</u>** Resident #1 – Physician ordered "Acetaminophen 325mg tablet, 2 tablets PO daily PRN." Medication label, medication order, and medication administration record does not reflect a PRN indication for aforementioned medication.	**PART 2** **<u>FUTURE PLAN</u>** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Remind caregivers to review doctor's order for medications for accuracy and completeness before leaving doctors office/clinic to make sure that all information, such as 5 Rights of medication administration including indications are properly indicated in the doctor's ~~order~~ order. Caregivers will initial the forms to signify that they were reviewed. Within the same day of the return from the doctor, Care Home operator will double check that caregivers indeed review the forms & initial it.	3/8/24

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; **FINDINGS** Resident #2 – No documented evidence of a tuberculosis clearance signed by a physician or advanced practice registered nurse (APRN).	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** Yes **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** 1) Returned the incomplete T.B Screening Form to Resident #2's Physician and requested that the check box indicating negative or positive to infection be properly checked off 2) Physician checked the box indicating negative to infection and initialed the correction (Copy enclosed) T.B Clearance Form	2/16/24

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; **<u>FINDINGS</u>** Resident #2 – No documented evidence of a tuberculosis clearance signed by a physician or APRN.	**PART 2** **<u>FUTURE PLAN</u>** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Remind caregivers to review all forms for accuracy and completeness before leaving the doctors office/clinic and not to assume that forms were completely filled out even if physician signed them. Caregivers will initial the forms to signify that they were reviewed. Within the same day of return from the doctor, the Care Home operator will double check that caregivers indeed review the forms & initial it.	3/8/24

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Licensee's/Administrator's Signature: ______________________

Print Name: MARLYN ACURAM

Date: 2/28/24

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

Print Name: MARLYN ACURAM

Date: 3/8/24

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