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Office of Health Care Assurance

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State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STATE OF HAWAII

Facility's Name: Martha's	CHAPTER 100.1
Address: 516 Ihe Street, Honolulu, Hawaii 96817	Inspection Date: March 22, 2016 Annual

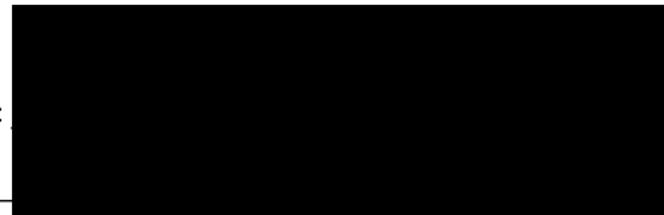
	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been 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.</p> <p>FINDINGS Household Member [redacted] No documentation of current, annual physical examination. Submit copy of current, annual physical examination with plan of correction.</p>	<p>① I'm the provider I will obtain current annual P.E or my household member will need to find somewhere else to live.</p> <p>② Household Member [redacted] P.E is attached.</p>	4/13/16
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (a) Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be obtained prior to a resident's admission to a Type I ARCH</p>		

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	<p>and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's responsible placement agency, and others authorized by the resident to review it.</p> <p>FINDINGS Resident [redacted] physician level of care assessment signed, [redacted] [redacted] but no level of care indicated on form.</p>	<p>① In the future I will check signed primary policy for completeness, if not resident will not be admitted.</p> <p>② A copy of level of care is attached.</p>	<p>4/13/16</p>

Licensee's/Administrator's Signature:

Print Name:

Date:



4/13/16