Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Luczon, Cipriana (ARCH)	**CHAPTER 100.1**
Address: **1765 Gulick Avenue Honolulu, Hawaii 96817**	**Inspection Date: January 5, 2016 Annual**

	Rules (Criteria)	Plan of Correction	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; **FINDINGS** Primary care giver no current first aid certification. **Submit current first aid certification with your plan of correction.**	I called my CPR/First Aid Instructor after I received my discrepancies. Instructor delivered my cards the following day. I had my CPR/First Aid renewed. -From now on I will make a checklist of necessary documents before the annual evaluations. Double check will reviewed by my caretaker assistant for proficiency	3-1-2017

☒	§11-100.1-9 Personnel, staffing and family requirements. (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall: Be currently certified in cardiopulmonary resuscitation;	My current CPR; First Aid card are being submitted.	3-1-2017
	FINDINGS Primary care giver no current CPR certification. **Submit current CPR certification with your plan of correction.**	- Make a list of necessary documents and ~~to~~ to be reviewed before the annual inspection to avoid the same discrepancies.	7/17/2017

Licensee/Administrator's Signature: _____

Print Name: CIPRIANA U. LUCZON

Date: 03-1-17

Licensee's/Administrator's Signature: _____

Print Name: Cipriana U. Luczon

Date: 7/16/2017