

Office of Health Care Assurance

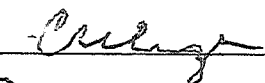
State Licensing Section


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
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p>FINDINGS Primary care giver no current first aid certification. Submit current first aid certification with your plan of correction.</p>	<p>I called my CPR, First Aid Instructor after I received my discrepancies. Instructor delivered my cards the following day. I had my CPR 12/17/16.</p> <p>-From now on I will make a checklist of necessary documents before the annual evaluations. Double check will be reviewed by my care taker assistant for proficiency</p>	3-1-2017

<input checked="" type="checkbox"/>	<p>§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;</p>	<p>My current CPR, First Aid cards are being submitted.</p>	<p>3-1-2017</p>
	<p>FINDINGS Primary care giver no current CPR certification. Submit current CPR certification with your plan of correction.</p>	<p>- Make a list of necessary documents and take to be reviewed before the annual inspection to avoid the same discrepancies.</p>	<p>7/17/2017</p>

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