Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Martin Obaldo	**CHAPTER 100.1**
Address: **94-572 Apii Place, Waipahu, Hawaii 96797**	**Inspection Date: March 27, 2018 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) 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
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** Family #1 no approved documentation of annual tuberculosis clearance.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** YES. THE FORM WAS SUBMITTED AND SIGNED BY THE PMD.	4/2/18

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** Family #1 no approved documentation of annual tuberculosis clearance.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** IN THE FUTURE, I WILL MAKE SURE THAT PROPER FORM WILL BE FILLED UP AND SIGNED BY THE PRIMARY DOCTOR. ALSO I WILL SET UP CONSTANT REMINDER ALERTING ME AHEAD OF TIME OF THE EXPIRATION DATE TO THE FF: A) CALENDAR B) DIGITAL PHONE C) COMPUTER	4/2/18

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** Family #2 no approved documentation of annual tuberculosis clearance.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** YES. THE FORM WAS SUBMITTED AND SIGNED BY THE PMD.	4/2/18

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** Family #2 no approved documentation of annual tuberculosis clearance.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** IN THE FUTURE, I WILL MAKE SURE THAT PROPER FORM WILL BE FILLED UP AND SIGNED BY ~~THE~~ PRIMARY DOCTOR. ALSO I WILL SET UP CONSTANT REMINDER ALERTING ME ~~AHEAD~~ OF TIME OF ~~THE~~ EXPIRATION ~~DATE~~ TO THE FF: A) CALENDAR B) DIGITAL PHONE C) COMPUTER	4/2/18

	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** PCG no current first aid card.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** YES. I WAS ABLE TO LOCATE THE ORIGINAL FIRST AID CARD DATED 11/20/2016 — 11/20/18.	3/29/18

	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** PCG no current first aid card.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** IN THE FUTURE, BEFORE MY ANNUAL INSPECTION I WILL MAKE SURE THAT I HAVE IN MY CARE HOME BINDER MY CURRENT F/A CARD AND CPR. I WILL SET UP CONSTANT REMINDER ABOUT ITS EXPIRATION AND RENEWAL TO MY DIGITAL PHONE, CALENDAR AND COMPUTER. P.S. ATTACHED COPY OF MY F/A CARD.	3/29/18

	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** SCG#1 no first aid card.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** YES, I WAS ABLE to LOCATE THE ORIGINAL FIRST AID CARD DATED 11/20/16 — 11/20/18.	3/29/18

	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** SCG#1 no first aid card.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** IN THE FUTURE, BEFORE MY ANNUAL INSPECTION I WILL MAKE SURE THAT I HAVE IN MY CARE HOME BINDER MY SUB CURRENT F/A CARD AND CPR. I WILL SET UP CONSTANT REMINDER ABOUT ITS EXPIRATION AND RENEWAL TO MY DIGITAL PHONE, CALENDAR AND COMPUTER. P.S. ATTACHED COPY OF MY SUBSTITUTE F/A CARD.	3/29/18

Licensee's/Administrator's Signature: _____

Print Name: MARTIN OBALDO

Date: 4/5/18