Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Leticia's Care Home	**CHAPTER 100.1**
Address: **1375 Ala Hoku Place, Honolulu, Hawaii 96819**	**Inspection Date: November 2, 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) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

RECEIVED
'18 MAY 13 P4:16

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** Employee #1 no current PE on file.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Informed employee #1 to pick up her new current physical examination from her doctor as soon as possible or after it's done. A copy will be received prior to SCG working in my home. 11/8/18	

RECEIVED
'18 NOV 13 P4:16
STATE

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** Employee #1 no current PE on file.	**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 a note that needs to be put in my calendar to remind myself to have her PE done within 3 months before it's due.	11/8/18

RECEIVED
'18 NOV 13 P4:16
STATE HEALTH DEPT.

	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** Employee #1 no current TB test or attestation on file.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Informed employee #1 to have her current TB test done and have the result as soon as possible or when it's done. a copy will be received prior to ~~SGT~~ SCG working in my home	11/8/18

RECEIVED
'18 NOV 13 P4:16
STATE OF UTAH

	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** Employee #1 no current TB test or attestation on file.	**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, a note needs to be put in my calendar to remind myself to have her tuberculin skin test done within 3 months before it's due. sorry 11/8/18 ~~11/8/18~~	

RECEIVED
'18 NOV 13 P4:16
STATE OF HAWAII
DEPT OF HUMAN SERVICES

Licensee's/Administrator's Signature: Tessie P. Fernando

Print Name: TESSIE P. FERNANDO

Date: 11/8/18

RECEIVED
'18 NOV 13 P4:16
STATE OF HAWAII
DEPT. OF HEALTH
STATE LIBRARY

COPY

Hawaii Department of Health
Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES/LICENSING/PLAN OF CORRECTION NOTICE

November 2, 2018

TO:

Tessie Fernando	**Leticia's Care Home**
1375 Ala Hoku Place	**Honolulu, Hawaii 96819**

ENCLOSED WITH THIS FORM:

☒ **Statement of Deficiencies (SOD)**	Annual Inspection **November 2, 2018**
☐ **SOD**	Annual Unannounced Visit **<Date and Time>**
☐ **SOD**	Complaint Investigation **<Date>**
☐ **License One (1) Year**	Untimely Submission of Plan of Correction (POC)
☐ **License One (1) Year**	Issued without SOD
☐ **License One (1) Year**	Issued with SOD. May be rescinded if POC is not acceptable or submitted in a timely manner.
☐ **License Previously Issued** (No Enclosure)	POC acceptable
☐ **License Less Than One (1) Year** of Months>	POC acceptable
☐ **License Less Than One (1) Year** f Months>	POC acceptable. Issued to maintain licensing month.
☐ **icense Less Than One (1) Year** Months>	Other <State Reason>
☐ **icense Less Than One (1) Year** Months>	Issued to allow time to complete the licensing process
☐ **mments/Advisements**	Issued to allow time for you to submit a POC
	See next page(s)

atement of Deficiencies. A list of non-compliant areas found during the inspection is enclosed.

an of Correction. The POC must be submitted within ten (10) working days of receipt of this letter.

OC must be written on the enclosed Statement of Deficiencies and Plan of Correction form using the
l format. Revisions to the form or facsimiles of this form will not be accepted and the POC will be
un-reviewed. As an alternative to using the form provided to you, please contact your Consultant
ic information regarding using attached pages for your POC.

nplete the POC by (1) Explaining how you corrected each deficiency and (2) Explaining what
o in the future to prevent similar deficiencies from recurring.

tact your Consultant if you have questions or need assistance with the POC. Our office hours are
.m. to 4:30 p.m., Monday through Friday.

es. Licenses may be revoked for just cause.

Office of Health Care Assurance