Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Noemi's ARCH	**CHAPTER 100.1**
Address: **94-919 Kumuao Street, Waipahu, Hawaii 96797**	**Inspection Date: March 14, 2019 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.

	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** No record of initial two-step tuberculosis skin test for Resident #1 available for review.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. **FINDINGS** No record of Primary Care Giver training for all Substitute Care Giver's available for review.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-84 Admission requirements. (b)(4) Upon admission of a resident, the expanded ARCH licensee shall have the following information: Evidence of current immunizations for pneumococcal and influenza as recommended by the ACIP; and a written care plan addressing resident problems and needs. **FINDINGS** Resident #1 - No records indicating resident either received or refused the pneumococcal vaccine.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____