

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name: Ohana Hale, LLC</b>	<b>CHAPTER 100.1</b>
<b>Address: 94-1063 Halelehua Street, Waipahu, Hawaii 96797</b>	<b>Inspection Date: May 10, 2019 Annual</b>

**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) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<input checked="" type="checkbox"/>	<p data-bbox="285 272 911 573">           §11-100.1-17 <u>Records and reports.</u> (c)            Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary.         </p> <p data-bbox="285 607 911 695"> <b><u>FINDINGS</u></b>            Resident #1-Incident reports occurred on 8/8/18, 1/12/19, and 1/28/19 were filed in the chart.         </p>	<p data-bbox="1272 272 1383 298"><b>PART 1</b></p> <p data-bbox="1024 345 1633 375"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p data-bbox="1016 418 1640 483"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p>	

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	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (f)(4)            General rules regarding records:</p> <p>All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency.</p> <p><b><u>FINDINGS</u></b>            Resident #1- No activity schedule found on record.</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p>	

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Licensee's/Administrator's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_