

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Aloha Adult DD Domiciliary Home, LLC	CHAPTER 89
Address: 2235 Auhuhu Street, Pearl City, Hawaii 96782	Inspection Date: April 17, 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) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

RECEIVED

MAY -1 11:17

STATE LICENSING SECTION

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-8 <u>Provision for services and review.</u> (d) All certified caregivers shall upgrade their skills by taking a minimum of eight hours, per year, of workshop or inservice programs approved by the division as a part of the requirement for the annual recertification.</p> <p>FINDINGS Caregiver #1 – Three (3) hour of training sessions completed within the last year. Five (5) hours shorts.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Caregiver #1 has completed all the required trainings within the last year. Enclosed is a copy of the training certificate that was not available on the day of the survey.</i></p> <p><i>Note: Caregiver # was in the process of moving and his certificates were packed in boxes. I actually asked him but was not available in time of the survey date.</i></p> <p><i>Please see attached copy of training certificate dated 6-23-18. It was an all day training a total of 8 hours.</i></p>	<p style="text-align: center;">4-23-19</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-8 <u>Provision for services and review.</u> (d) All certified caregivers shall upgrade their skills by taking a minimum of eight hours, per year, of workshop or inservice programs approved by the division as a part of the requirement for the annual recertification.</p> <p><u>FINDINGS</u> Caregiver #1 – Three (3) hour of training sessions completed within the last year. Five (5) hours shorts.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future when we attend trainings I will borrow his certificate and make a copy. As I will asked to keep his certificate in my file, and he needs copy I will just give him a copy, to be sure that the certificates of training will be on binder at all times</i></p>	<p style="text-align: center;">4-23-19</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-9 <u>General staff health requirements.</u> (a)(1) All individuals living in the facility including those who provide services directly to residents shall have documented evidence that they have had examination by a physician prior to their first contact with the residents of the home and thereafter as frequently as the department deems necessary. The examination shall be specifically oriented to rule out communicable disease and shall include tests for tuberculosis.</p> <p>If an initial tuberculin skin test is negative, a second tuberculin skin test shall be done after one week, but no later than three weeks after the first test. The results of the second test shall be considered the baseline test and shall be used to determine appropriate treatment follow-up. If the second test is negative, it shall be repeated once yearly thereafter unless it becomes positive.</p> <p>FINDINGS Caregiver #1 – Physician signed and dated a TB Risk Assessment and Attestation Screening Form, however, PPD skin test result was left blank. No documentation that shows PPD skin test was positive.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>I will verify my checklist on requirements and check the expiration dates. Remind my caregivers to obtain 4-23-19 all requirements before the due date. make sure all the forms are filled up before leaving the doctors office. caregiver #1 has the clearance from the Dept of Health. It was not up to date at the time and date of the survey.</i></p> <p><i>Please see attached copy for TB clearance from Dept of Health with date of X-ray on August 26, 2016.</i></p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-9 <u>General staff health requirements.</u> (a)(1) All individuals living in the facility including those who provide services directly to residents shall have documented evidence that they have had examination by a physician prior to their first contact with the residents of the home and thereafter as frequently as the department deems necessary. The examination shall be specifically oriented to rule out communicable disease and shall include tests for tuberculosis.</p> <p>If an initial tuberculin skin test is negative, a second tuberculin skin test shall be done after one week, but no later than three weeks after the first test. The results of the second test shall be considered the baseline test and shall be used to determine appropriate treatment follow-up. If the second test is negative, it shall be repeated once yearly thereafter unless it becomes positive.</p> <p><u>FINDINGS</u> Caregiver #1 – Physician signed and dated a TB Risk Assessment and Attestation Screening Form, however, PPD skin test result was left blank. No documentation that shows PPD skin test was positive.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>In the future before leaving the doctor's office I will check the forms if it is filled properly. If not asked the doctor to fill it up before leaving his office.</i></p>	<p style="text-align: center;">4-23-19</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-12 <u>Structural requirements for licensure.</u> (b) Once licensed, the administrator shall be responsible for ensuring that the facility is maintained in compliance with all state and county zoning, building, fire, sanitation, housing and other codes, ordinances, and laws.</p> <p><u>FINDINGS</u> In Bedroom #2, the paint approximately 20cm x 10cm was peeling on the wall by the resident's bed.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>yes it was painted already. as soon as I noticed some damages in the facility correct or fixed it immediately. Keep the facility maintained all times.</i></p>	<p><i>4-23-19</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-12 <u>Structural requirements for licensure.</u> (b) Once licensed, the administrator shall be responsible for ensuring that the facility is maintained in compliance with all state and county zoning, building, fire, sanitation, housing and other codes, ordinances, and laws.</p> <p><u>FINDINGS</u> In Bedroom #2, the paint approximately 20cm x 10cm was peeling on the wall by the resident's bed.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>get in a habit to go around the facility everyday. Check the lights switch, and damages in the facility. The facility must be well maintained all the time.</i></p>	<p style="text-align: center;"><i>4-23-19</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-12 <u>Structural requirements for licensure.</u> (b) Once licensed, the administrator shall be responsible for ensuring that the facility is maintained in compliance with all state and county zoning, building, fire, sanitation, housing and other codes, ordinances, and laws.</p> <p><u>FINDINGS</u> Caregiver stated that dishes are sanitized twice a week.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>I sanitized the dishes and utensils every after meal to 1 to 3 teaspoon regular bleach to 1 gallon of water. Soak dishes and utensils in the bleach solution for 1 minute then rinse and air dry.</i></p>	<p style="text-align: center;"><i>4-23-19</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-12 <u>Structural requirements for licensure.</u> (b) Once licensed, the administrator shall be responsible for ensuring that the facility is maintained in compliance with all state and county zoning, building, fire, sanitation, housing and other codes, ordinances, and laws.</p> <p><u>FINDINGS</u> Caregiver stated that dishes are sanitized twice a week.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future always follow the guidelines in washing dishes. Mix 1 to 3 teaspoon of regular bleach to 1 gallon of water and soak the dishes and utensils for 1 minute every after meal. Then rinse it thoroughly and air dry.</i></p>	<p style="text-align: center;">4-23-19</p>

Licensee's/Administrator's Signature: Im Steffens-Crawford

Print Name: IMELDA M. STEFFENS-CRAWFORD

Date: 4-26-19