

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Bueno #2	CHAPTER 100.1
Address: 94-916 Kumuao Street, Waipahu, Hawaii 96797	Inspection Date: February 7, 2020 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.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.</p> <p><u>FINDINGS</u> Multiple bottles of cleaning agents stored unsecured in the bathroom closet.</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>Latch with lock and key was installed on closet door.</p>	<p>02/08/20</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(6) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Coordinate care giver training, hospital discharge, respite, home transfers and other services as appropriate. Facilitate, advocate and mediate for expanded ARCH residents, care givers and service providers to ensure linkages and provision of quality care for the optimal function of the expanded ARCH resident;</p> <p><u>FINDINGS</u> Resident #1 - Documentation of care plan training by case manager with substitute care givers (SCG) #1 and #2 unavailable for review. Submit copy of completed care plan training by case manager for SCG #1 and #2.</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>Notified Case manager on 02/10/20 that SCG #1 #1 and #2 is missing documentation of completed care plan training. Per CM, training will be conducted on 02/28/20</p>	<p>02/28/20</p>

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Licensee's/Administrator's Signature: 

Print Name: Feli Caballero

Date: 03/30/20