Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Aloha Nui Care Home LLC	**CHAPTER 100.1**
Address: **1662 Hookani Street, Pearl City , Hawaii, 96782**	**Inspection Date: August 3, 2021 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. (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** House hold member #1 and #2: no documented evidence of annual physical examination.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** House hold member 1 and 2 completed annual physical Exam and I kept this into ARCH folder.	9/1/2024

STATE OF HAWAII
STATE

21 NOV 15 P3:26

	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** House hold member #1 and #2: no documented evidence of annual physical examination.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will keep track house hold member's physical Exam due date. I made one sheet with this information to keep track of the expiration dates. Also I can set my Alarm in my phone, so I can aware of that. STATE OF HAWAII DOH-EH NOV 15 P3:27	9/1/2024 12.

	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** House hold member #1 and #2: no documented evidence of annual tuberculosis clearance.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** House hold member 1 and 2 completed annual TB test and I kept this to ARCH folder.	9/1/2024

STATE OF HAWAII
STATE [illegible]
'21 NOV 15 P3:27

	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** House hold member #1 and #2: no documented evidence of annual tuberculosis clearance.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will keep tract house hold member's annual TB due date. I made one sheet with this information to keep track of the expiration date. Also I can set my alarm in my phone, so I can aware of that.	9/1/2021

STATE OF HAWAII
DOH-HSS

21 NOV 15 P3:27

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall: Be currently certified in cardiopulmonary resuscitation; **FINDINGS** Substitute care giver #1: No documented evidence of cardiopulmonary certification.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** SCG completed CPR class to renew and I kept this to ARCH binder.	9/15/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall: Be currently certified in cardiopulmonary resuscitation; **FINDINGS** Substitute care giver #1: No documented evidence of cardiopulmonary certification.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will keep track SCG's CPR due date. I made one sheet with this information to keep track of expiration dates. Also I can set my alarm in my phone, so I can aware of that.	9/15/2024

STATE OF NEW MEXICO
STATE [illegible]

21 NOV 15 P3:27

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(1) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Documentation of primary care giver's assessment of resident upon admission; **FINDINGS** Resident #1: admission assessment not signed by resident, guardian, or legal representative.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I have POA sign on the admission assessment form.	8/14/2021

STATE OF HAWAII
DOH #004
STATE LICENSURE

21 NOV 15 P3:27

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(1) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Documentation of primary care giver's assessment of resident upon admission; **FINDINGS** Resident #1: admission assessment not signed by resident, guardian, or legal representative.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will prepare all ARCH papers upon admission and will have POA sign upon admission. I will make admission checklist in our care home binder, so when admission is scheduled, I will check every single papar needed sign.	8/14/2021

21 NOV 15 P3:27

STATE OF HAWAII
DOH
STATE LICENSING

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-19 Resident accounts. (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative. **FINDINGS** Resident #1: No documented evidence of financial statement.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I have POA signed on the financial statement.	9/15/2021

STATE OF HAWAII
DEPT. OF
STATE LIC. BRANCH

21 NOV 15 P3:27

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-19 Resident accounts. (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative. **FINDINGS** Resident #1: No documented evidence of financial statement.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will prepare All ARCH papers upon admission and will have POA sign upon admission. I will make admission check list in our care home binder, so when admission is scheduled, I will check every single paper needed sign	8/14/2024

'21 NOV 15 P3:27

STATE OF [illegible]
DOH
STATE LICENSING

Licensee's/Administrator's Signature: _____

Print Name: Minhye Takamatsu

Date: 11/4/2021