Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Judy's	**CHAPTER 100.1**
Address: **934 Anohea Way, Wailuku, Hawaii, 96793**	**Inspection Date: June 25, 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
☒	§11-100.1-8 Primary care giver qualifications. (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall: Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current; **FINDINGS** Primary care giver: No documented evidence of six (6) hours of continuing education.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I have succesfully completed a six hr. of contact study w/ certificate. STATE OF HAWAII OBH-DRO STATE LICENSING	9/17/21 '21 SEP 22 P3:19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-8 Primary care giver qualifications. (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall: Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current; **FINDINGS** Primary care giver: No documented evidence of six (6) hours of continuing education.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future I will try to attend and successfully a minimum of six hrs. of continuing education, also I will make a reminder for me to attend workshops and put it in my carehome binder.	9/17/21

STATE OF HAWAII
DEPT. OF HEALTH
STATE HEALTH PLANNING

21 SEP 22 P3:19

	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** Substitute care giver #1: 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** substitute care giver #1 has already acquired annual T.B. clearance. Its already on file.	9/17/21

STATE OF HAWAII
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STATE LICENSING

21 SEP 22 P3:19

	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** Substitute care giver #1: 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?** Make a reminder to obtain T.B. clearance before the annual inspection + put it in my care home binder	9/17/21

	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** Substitute care giver #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** substitute caregiver # 2 has already obtained annual T.B. clearance. Its already on file.	9/17/21

STATE OF HAWAII
DEPT. OF HUMAN
STATE LICENSING

21 SEP 22 P3:19

	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** Substitute care giver #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?** Make a reminder to obtain T.B. clearance before the annual inspection & put it in my care home binder.	9/17/21

STATE OF HAWAII
DEPT. OF HUMAN SERVICES
STATE LICENSING

21 SEP 22 P3:19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (f)(1) General rules regarding records: All entries in the resident's record shall be written in black ink, or typewritten, shall be legible, dated, and signed by the individual making the entry; **FINDINGS** Resident #1: Blue ink used in medication administration record	**Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** STATE OF HAWAII DOH/OHSA STATE LICENSING '21 SEP 22 P3:19	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (f)(1) General rules regarding records: All entries in the resident's record shall be written in black ink, or typewritten, shall be legible, dated, and signed by the individual making the entry; **FINDINGS** Resident #1: Blue ink used in medication administration record	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future I will make sure to use only black ink pen in doing my medication Administration. I will make a reminder to use only black ink pen and put it in my care home binder.	9/17/21

STATE OF HAWAII
BOARD OF NURSING
STATE LICENSING

21 SEP 22 P3:20

Licensee's/Administrator's Signature: Judita Dagdag

Print Name: Judita Dagdag

Date: 9/17/21