

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Josie's Ohana	CHAPTER 100.1
Address: 1388 Haloa Drive, Honolulu, Hawaii 96818	Inspection Date: April 1, 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) 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>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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.</p> <p>FINDINGS Substitute Caregiver (SCG) #1 – Annual physical exam unavailable for review. Submit a copy with plan of correction.</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>SCG #1 (JM) is no longer my substitute he gave us out notice</i></p>	<p><i>04/17/2021</i></p> <p><i>Jm</i></p> <p style="text-align: right;">21 APR 22 12:04</p> <p style="text-align: right;">STATE OF HAWAII DOH-ONCA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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.</p> <p><u>FINDINGS</u> Substitute Caregiver (SCG) #1 – Annual physical exam unavailable for review. Submit a copy with plan of correction.</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>Next time I will make it sure all my substitute have up to date P.E. annually. This will be on my check list.</i></p>	<p style="text-align: right;"><i>04/17/2021</i></p> <p style="text-align: right;"><i>[Signature]</i></p> <p style="text-align: center;">STATE OF HAWAII DOH-OHCA STATE LICENSING</p> <p style="text-align: right;">21 APR 22 P12:04</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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.</p> <p><u>FINDINGS</u> SCG #1 – Annual TB clearance unavailable for review. Submit a copy with plan of correction.</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>SCG #1 (JM) is no longer my substitute he quit w/out notice.</i></p>	<p><i>04/17/2021</i></p> <p><i>Jay</i></p>

STATE OF HAWAII
 DOH-OHCA
 STATE LICENSING

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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.</p> <p><u>FINDINGS</u> SCG #1 – Annual TB clearance unavailable for review. Submit a copy with plan of correction.</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>SCG #1 (JM) I will make sure 04/17/2022 all my substitute will have TB test on time. This will be on my checklist</i></p>	<p style="text-align: center;"><i>JJ</i></p> <p style="text-align: center;">21 APR 22 P12 04</p> <p style="text-align: center;">STATE OF HAWAII DOH-OHCA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p><u>FINDINGS</u> SCG #2 – Current first aid certification unavailable for review. Submit a copy with plan of correction.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>First aid certificate was obtained during survey</i></p>	<p><i>04/17/2021</i></p> <p><i>[Signature]</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p><u>FINDINGS</u> SCG #2 – Current first aid certification unavailable for review. Submit a copy with plan of correction.</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 I'll make a tracking log of all first aid certifications + obtain caregiver certification prior to recertification date</i></p>	<p><i>07/19/21</i></p> <p><i>[Signature]</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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:</p> <p>Be currently certified in cardiopulmonary resuscitation;</p> <p>FINDINGS SCG #2 – Current CPR certification unavailable for review. Submit a copy with plan of correction.</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>CPR certificate was obtained 04/17/2021 & shown at time of survey jz</i></p>	<p style="text-align: right;">21 APR 22 PM 12:04</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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:</p> <p>Be currently certified in cardiopulmonary resuscitation;</p> <p><u>FINDINGS</u> SCG #2 – Current CPR certification unavailable for review. Submit a copy with plan of correction.</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 del make sure a tracking log of all CPR certification & obtain caregiver certification prior to expiration date.</i></p>	<p><i>07/19/2021</i></p> <p><i>[Signature]</i></p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (d) Current menus shall be posted in the kitchen and in a conspicuous place in the dining area for the residents and department to review.</p> <p><u>FINDINGS</u> Resident #4 – Low sodium diet menu unavailable for review.</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>low sodium diet was with the previous care home operator. Will re-assess with PEP P.E. for regular diet.</i></p>	<p style="text-align: right;"><i>04/17/2021</i></p> <p style="text-align: right;"><i>[Signature]</i></p> <p style="text-align: right;">21 APR 22 112:04</p> <p style="text-align: right;">STATE OF HAWAII DOH-DHCA STATE LICENSING</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit.</p> <p><u>FINDINGS</u> Resident #1 – Diet order unavailable for review. Submit a copy with plan of correction.</p> <p style="text-align: right;">STATE OF HAWAII DOH-DHCA STATE LICENSING</p> <p style="text-align: right;">JUN -4 PM 2:12 '21</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>Resident #1 - Diet order was obtained from her P.O.P dated 4/14/21. on file send me copy to my surveyor</i></p>	<p><i>5/26/2024</i></p> <p><i>[Signature]</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit.</p> <p><u>FINDINGS</u> Resident #1 – Diet order unavailable for review. Submit a copy with plan of correction.</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 I will make a reminder note to obtain a diet order from the doctor every year. I will place a reminder note on my calendar/ cell phone</i></p>	<p style="text-align: right;"><i>7/19/21</i></p> <p style="text-align: right;"><i>Jy</i></p>

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<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> Toxic chemicals (Gallon jug of Odoban and cleaning spray) stored unsecure in bathroom cabinet.</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 style="text-align: center;"><i>ODOBAN + cleaning spray was secured right away</i></p>	<p style="text-align: center;"><i>04/17/2021</i></p> <p style="text-align: center;"><i>[Signature]</i></p> <p style="text-align: center;">21 APR 22 112 05</p> <p style="text-align: center;">STATE OF HAWAII DH-CHCA STATE LICENSING</p>

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<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> Toxic chemicals (Gallon jug of Odoban and cleaning spray) stored unsecure in bathroom cabinet.</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>I will post a sign to remind caregivers to lock all toxic chemicals in cabinet when not being use.</i></p> <p><i>I will post sign in the bathroom.</i></p>	<p style="text-align: right;"><i>7/19/21</i></p> <p style="text-align: right;"><i>Jy</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(4) 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:</p> <p>A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;</p> <p>FINDINGS Residents #1,2,3 – Annual TB clearance unavailable for review. Submit a copy with plan of correction.</p> <p style="text-align: center;">STATE OF HAWAII DOH-0HCA STATE LICENSING</p> <p style="text-align: center;">21 JUN -4 PM 1:3</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>Obtained copy 5 minute phony Resident # 1, 2, 3; annual TB clearance copies on clients charts</i></p>	<p style="text-align: right;"><i>5/28/21</i></p> <p style="text-align: right;"><i>[Signature]</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(4) 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:</p> <p>A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;</p> <p><u>FINDINGS</u> Residents #1,2,3 – Annual TB clearance unavailable for review. Submit a copy with plan of correction.</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 I will make a tracking log when all residents TB clearances are due each year. I will review log each month.</i></p>	<p style="text-align: right;"><i>07/19/21</i></p> <p style="text-align: right;"><i>[Signature]</i></p>

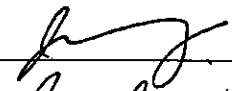
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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><u>FINDINGS</u> Resident #1 - Annual physical exam unavailable for review. Submit a copy with plan of correction.</p> <p style="text-align: center;">STATE OF HAWAII DOH-0HCA STATE LICENSING</p> <p style="text-align: center;">21 JUN -4 P12:13</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>Obtained annual P.E. from PCP copy 4/27/2021 on file</i></p> <p><i>I'll make a list on my calendar each clients P.E. annually to avoid forgetfulness & as my reminder each month whose having P.E. annually</i></p>	<p><i>5/28/21</i></p> <p><i>JY</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><u>FINDINGS</u> Resident #1 – Annual physical exam unavailable for review. Submit a copy with plan of correction.</p> <p style="text-align: right;">STATE OF HAWAII DOH-OHCA STATE LICENSING</p> <p style="text-align: right;">21 JUN -4 PM 12:13</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>I will make sure to write each client's name in the calendar for their annual P.E. as my reminder dtd in my phone etc.</i></p>	<p><i>5/28/2021</i></p> <p><i>[Signature]</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (p)(5) Miscellaneous:</p> <p>Signaling devices approved by the department shall be provided for resident's use at the bedside, in bathrooms, toilet rooms, and other areas where residents may be left alone. In Type I ARCHs where the primary care giver and residents do not reside on the same level or when other signaling mechanisms are deemed inadequate, there shall be an electronic signaling system.</p> <p><u>FINDINGS</u> Signaling device unavailable in bathroom.</p> <p>Resident #4 – Signaling device at bedside unavailable.</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>Signaling device in the bathroom was changed from battery to manual bell.</i></p> <p><i>Resident #4 signaling device was located, it was misplaced by the resident</i></p>	<p><i>04/17/21</i> <i>Jay</i></p> <p><i>40/17/2021</i> <i>Jay</i></p> <p style="text-align: center;">21 APR 22 112 05</p> <p style="text-align: center;">STATE OF HAWAII DOH-OHCA STATE LICENSING</p>

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<p><input checked="" type="checkbox"/> §11-100.1-23 <u>Physical environment.</u> (p)(5) Miscellaneous:</p> <p>Signaling devices approved by the department shall be provided for resident's use at the bedside, in bathrooms, toilet rooms, and other areas where residents may be left alone. In Type I ARCHs where the primary care giver and residents do not reside on the same level or when other signaling mechanisms are deemed inadequate, there shall be an electronic signaling system.</p> <p>FINDINGS Signaling device unavailable in bathroom.</p> <p>Resident #4 – Signaling device at bedside unavailable.</p> <p style="text-align: right;">STATE OF HAWAII DOH-0HCA STATE LICENSING</p> <p style="text-align: right;">21 JUN -4 PM:13</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>Replace battery in bathroom signaling device. 5/28/21</i></p> <p><i>In the future I'll include in my list to check all my signaling devices for function & availability.</i></p> <p><i>Resident #4 - Remind him to return his signaling device on his bedside table also remind my SCG to check for assurance it there.</i></p> <p><i>In the future will make sure that his signaling device is always on his bedside table also remind & have my staff/SCG to check it before the shift end. 5/28/21</i></p>	<p style="text-align: right;"><i>5/28/21</i></p> <p style="text-align: right;"><i>for</i></p> <p style="text-align: right;"><i>5/28/21</i></p> <p style="text-align: right;"><i>for</i></p>

Licensee's/Administrator's Signature: 
Print Name: Joseph V. Rodenryj
Date: 07/19/2021

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