

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Rose Hwang's Care Home	CHAPTER 100.1
Address: 1755 Palamoi Street, Pearl City, Hawaii 96782	Inspection Date: March 29, 2022 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.

STATE OF HAWAII
DOH-CHCA
STATE LICENSING

22 JUN 14 P 1:41

	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) #1,2,3 – Annual physical exam 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>Yes, corrected the deficiency.</p> <p>PCG asked all caregivers #1, 2, 3 to schedule an appointment w/ their PCP, ASAP and submit the annual PE. And they all did right away and submitted in timely manner.</p> <p>Copy of sub #1, 2, 3's annual PE is submitted!</p>	<p>'22 MAY 24 PT :06</p> <p>STATE OF HAWAII DOH-ONCA STATE LICENSING</p> <p>Sub. #1 on 4/16/22</p> <p>Sub. #2 on 4/19/22</p> <p>Sub. #3 on 4/21/22</p>

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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 – Initial and annual TB clearance unavailable SCG #2 – Annual TB clearance unavailable</p> <p>Submit a copy with plan of correction.</p> <p>STATE OF HAWAII DOH-CHCA STATE LICENSING MAY 24 P1:06 '22</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>Yes, corrected the deficiency. Subx1, and 2 submitted ^{a copy} as soon as they could.</p> <p>Copy submitted:</p> <p>Subx1 4/16/22</p> <p>Subx2 4/19/22</p>	

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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> (d) The primary caregiver or licensee acting as the primary caregiver must be present in the Type I ARCH at all times unless the primary caregiver or licensee acting as the primary caregiver has secured a substitute caregiver to provide temporary coverage for the primary caregiver or licensee acting as the primary caregiver.</p> <p><u>FINDINGS</u> Residents were left unattended while all caregivers attended educational trainings on 1/15/22, 1/28/22, and 2/5/22.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

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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> (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 #1 – Valid first aid certification unavailable</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>Yes, corrected the deficiency. PIC received copy on 4/5/22</p> <p>she (sub*1) had it but she forgot to asked for copy from another job, Arcadia.</p> <p>she finally got it copy for me on 4/5/22</p> <p>Copy submitted!</p>	<p>22 APR 26 4:36 PM STATE OF OHIO DOH OHIO STATE LICENSING</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 #1 – Valid first aid certification unavailable</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>PCG created graph showing Name, Annual PE, TB skin Test, CPR & 1st Aid, etc to keep track w/ their own responsibility and turn in on time to prevent from future happening again.</p>	<p>5/13/22</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><u>FINDINGS</u> SCG #1 – Valid CPR certification unavailable</p> <p>STATE OF HAWAII DOH-DOHA STATE LICENSING</p> <p>MAY 24 P1:06 '22</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>Yes, corrected the deficiency. PCG asked sub^{XX} 1 to turn in Valid CPR as soon as possible finally obtained!</p> <p>Copy obtained & in binder. 5/13/22</p>	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.</p> <p><u>FINDINGS</u> Resident #2 – Two bottles of medicated eye drops stored unsecured on resident's nightstand</p>	<p>PART 1 '22 MAY 24 P1:06</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Yes, corrected the deficiency.</p> <p>PCG put away right away in resident #2 locked compartment and it will in locked after each use.</p> <p>PCG posted "All medications, vitamins & Supplements including eye drops should be in locked compartment at all times!"</p> <p>on all residents medication locked compartments. So 5/24/22</p> <p>12 it should never happen again in the future.</p>	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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 – Initial and annual TB clearance unavailable. 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>Initial 2 step TB Test & Annual TB Test completed & Submitted. See attached.</p>	<p>6/14/22</p> <p>22 JUN 14 P1:41</p> <p>STATE OF HAWAII DEPT. OF HEALTH STATE LICENSING</p>

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STATE OF MICHIGAN
DEPARTMENT OF
STATE LICENSING

22 JUN 14 P1:41

Licensee's/Administrator's Signature: _____

Print Name: _____ Rose L. Hwang

Date: _____ 4/26/22

STATE OF HAWAII
DOH-ORCA
STATE LICENSING

22 APR 26 PM 2:37

Licensee's/Administrator's Signature: _____



Print Name: _____

Rose L. Hwang

Date: _____

5/24/22

STATE OF HAWAII
DOI-ONCA
STATE LICENSING

Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____

[Handwritten Signature]
Rose L. Hwang
6/14/22

22 JUN 14 P 1:41
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