Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Debora's	**CHAPTER 100.1**
Address: **1773 Piikea Street, Honolulu, Hawaii 96818**	**Inspection Date: August 22, 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) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-3 Licensing. (b)(1)(I) Application. In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application: Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law; **FINDINGS** No documented evidence of fieldprint background check for caregivers and house hold members.	'22 NOV -2 A9:33 **PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I corrected the defeciency by making an appointment with fieldprint for all caregivers and household members. Appointment on Nov. 10, 2022.	Oct. 03/2022

	RULES (CRITERIA)	PLAN OF CORRECTION '22 NOV -2 A9:33	Completion Date
☒	§11-100.1-3 Licensing. (b)(1)(I) Application. In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application: Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law; **FINDINGS** No documented evidence of fieldprint background check for caregivers and house hold members.	**PART 2** STATE OF HAWAII DOH-OHCA STATE LICENSING **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 obtain background check to all members of the family 18 years old and older and caregivers before working in the care home. I will include this in the yearly list of requirements calendar posted on the wall which is visible to all the staff. To make sure not to forget in the future.	10/03/22

	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** Resident #2, Resident #3: No documented evidence of annual physical exam.	'22 NOV -2 A9:33 **PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I already have obtain the Annual PE for both Resident #2 and Resident #3. And already in their chart ready for review.	9/26/22

	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 Resident #2, Resident #3: No documented evidence of annual physical exam.	PART 2 '22 NOV -2 A9:33 FUTURE PLAN STATE OF HAWAII DEPARTMENT OF HEALTH USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? I will make a list of all the Residents and the Dates that needed to renew their PE and Place it on my Daily Activity Calendar to ensure it won't happen again.	9/26/22

	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** No documented evidence of annual tuberculosis clearance for all caregivers and house hold members.	PART 1 NOV -2 A9:33 **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** TB testing done for all Caregivers and household members done on 10/3/22 and 10/25/22. TB test forms filed on Care Home operations folder.	10/25/22

	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** No documented evidence of annual tuberculosis clearance for all caregivers and house hold members.	**PART 2** NOV -2 A9:33 **FUTURE PLAN** STATE OF HAWAII DOH-DHCA **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** My future plan is to make a list of all the requirements for all caregivers and family members in my yearly calendar Posted on the wall wyc is visible to all the staff which indicate the Dates that needs to be renewed. To make sure that it wont happen again.	10/10/22

	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** Resident #4: No documented evidence of annual tuberculosis clearance.	**PART 1** 22 NOV -2 A9:33 **DID YOU CORRECT THE DEFICIENCY?** STATE OF HAWAII DOH-OHCA **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I corrected the defeciency by calling the PCP that Resident #4 needs TB test renewal. Gotten appointment by (10/25/22)	10/25/22

	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** Resident #4: 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 make a note on top of the client chart the date when the TB test needs to be done to make sure it wont happen again.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. **FINDINGS** Resident #3: Expired medication unlocked in living room. Discarded during inspection.	'22 NOV -2 A9:33 STATE OF HAWAII DOH OHCA STATE LICENSING **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	11/22/22

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. **FINDINGS** Resident #3: Expired medication unlocked in living room. Discarded during inspection.	**PART 2** '22 NOV -2 A9:34 **FUTURE PLAN** STATE OF HAWAII DOH/HSCA **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** My Future plan is to make sure that all expired medications needs to be discarded right away. I will make a reminder (note) in front of the medication cabinet. To ensure that it wont happen again.	8/22/22

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-23 **Physical environment.** (e) Resident living areas shall be designed and equipped for the safety, comfort, and privacy of the resident; **FINDINGS** Resident #2: Camera located in bedroom for monitoring. No documented evidence of consent by resident or guardian.	**PART 1** '22 NOV -2 A9:34 **DID YOU CORRECT THE DEFICIENCY?** STATE OF HAWAII DCH OHCA STATE SURVEYING **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I corrected the deficiency by informing the family that a monitor with camera was placed on the clients room to monitor him at night due to frequent restlessness and danger of falling. Family agree and signed a consent. Consent signed by family, (Resident POA.)	9/28/22

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-23 Physical environment. (e) Resident living areas shall be designed and equipped for the safety, comfort, and privacy of the resident; **FINDINGS** Resident #2: Camera located in bedroom for monitoring. No documented evidence of consent by resident or guardian.	**PART 2** '22 NOV -2 A9:34 **FUTURE PLAN** STATE OF HAWAII DOH-OHCA **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will make a note that using a monitor inside a Residents room needs permission from the residents family (POA) before using. I will place the note in the Care Home Policy to remind me that every Admission of a client is made.	9/28/22

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-23 Physical environment. (g)(3)(I) **Fire prevention protection.** Type I ARCHs shall be in compliance with, but not limited to, the following provisions: Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either: **FINDINGS** Resident #1,#2,#3: Three (3) residents certified as non self-preserving. License capacity allows for two (2) non self-preserving residents.	**PART I** 22 NOV -2 A9:34 **DID YOU CORRECT THE DEFICIENCY?** STATE DOH-DHCA CARE REVIEW **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I requested a re-assessment for resident #1 since client is alert and oriented. She knows what's going on around her. able to express herself and ask what she needs. Resident #1 is now Case Home level and only 2 non self preserving client in the home.	10/24/22

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-23 Physical environment. (g)(3)(I) **Fire prevention protection.** Type I ARCHs shall be in compliance with, but not limited to, the following provisions: Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either: **FINDINGS** Resident #1,#2,#3: Three (3) residents certified as non self-preserving. License capacity allows for two (2) non self-preserving residents.	**PART 2** '22 NOV -2 A9:34 **FUTURE PLAN** STATE OF HAWAII DCH-DHCA STATE LICENSING **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 check level of care of the client before Admission. I will make a note on my Admission requirements to check Either the client is level #1 or level #2.	9/20/22

	RULES (CRITERIA)	PLAN OF CORRECTION '22 NOV -2 A9:34	Completion Date
☒	§11-100.1-23 Physical environment. (g)(3)(I) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either: **FINDINGS** Resident #2: No documented evidence of self-preservation assessment.	**PART 1** STATE OF HAWAII **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I corrected the deficiency by asking the MD to fill out the preservation form. Client is now level #1.	9/26/22

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-23 Physical environment. (g)(3)(I) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either: **FINDINGS** Resident #2: No documented evidence of self-preservation assessment.	22 NOV 2 A9:34 **PART 2** STATE OF HAWAII DOH ONCA CARE LICENSING **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will make sure that all necessary Admission form. Like self preservation Assessment is properly filled out and signed by the discharging MD. I will include this in my Admission requirements to make sure it wont happen again.	9/26/22

	RULES (CRITERIA)	PLAN OF CORRECTION '22 NOV -2 A9:34	Completion Date
☒	§11-100.1-23 Physical environment. (p)(5) Miscellaneous: 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. **FINDINGS** Resident #2: No signaling device at bedside.	**PART 1** STATE OF HAWAII STATE ENGINEER **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I corrected the deficiency by providing portable signaling device at his bedside table that the client can reach.	9/22/22

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☒	§11-100.1-23 Physical environment. (p)(5) Miscellaneous: 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. **FINDINGS** Resident #2: No signaling device at bedside.	'22 NOV -2 A9:34 **PART 2** STATE OF HAWAII OFFICE STATE LICENSING **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 that all the clients have signaling device at their reach. Need to remind all caregiver's to provide call bell all the time and checking client every 2° to make sure the call bell is within his reach. Posted reminder on clients room door.	

Licensee's/Administrator's Signature: _____

Print Name: Debora Castro

Date: October 31, 2022

'22 NOV -2 A9:34

STATE OF HAWAII
DCH-DHCA
STATE LICENSING