

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Irene B. Alipio	CHAPTER 100.1
Address: 733 Iluna Place, Kahalui, Hawaii 96732	Inspection Date: June 28, 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.

STATE OF HAWAII
DHHS
STATE LICENSING

22 DEC -7 10:14

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>. (b)(1)(I) Application.</p> <p>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:</p> <p>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;</p> <p><u>FINDINGS</u> Primary Care Giver (PCG), Substitute Care Giver (SCG) #1, SCG #2, SCG #3 – No current documented evidence that the aforementioned individuals have no prior felony or abuse convictions in a court of law.</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="font-size: 2em; text-align: center;"><i>It was completed 7/27/2022 @ 9:00</i></p>	<p style="text-align: right; color: blue;">22 DEC -7 AM:14</p> <p style="text-align: right; color: blue; font-size: 0.8em;">STATE ARCHIVE DCH-CHCA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>. (b)(1)(I) Application.</p> <p>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:</p> <p>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;</p> <p><u>FINDINGS</u> PCG, SCG #1, SCG #2, SCG #3 – No current documented evidence that the aforementioned individuals have no prior felony or abuse convictions in a court of law.</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 style="text-align: center;"><i>In the future I will make an appointment together with my substitute caregivers. And since the documentation is on file.</i></p>	<p style="text-align: right;">22 DEC -7 A8:15</p>

STATE OF HAWAII
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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> PCG – No documented evidence of a current annual tuberculosis clearance by s physician or advanced practice registered nurse (APRN).</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>We completed in July 27, 2022</i></p>	<p style="text-align: center;"><i>7/27/2022</i></p> <p style="text-align: right; color: blue;">22 DEC -7 A8:15 STATE LICENSING DOH-GHCA 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> (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> PCG – No documented evidence of a current annual tuberculosis clearance by s physician or APRN.</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 style="text-align: center;"><i>my substitute caregiver and double check. I will, make sure the ^{to} documentation is on file. PCG and the substitute caregiver.</i></p>	<p style="text-align: right;">22 DEC -7 A8 15</p> <p style="text-align: right; font-size: small;">STATE OF MARYLAND DOH-011A STATE LICENSING</p>

	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 #4 – No documented evidence of a current tuberculosis clearance by a physician or APRN.</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>Yes. Me and my resident completed Sept. 8, 2022</i></p>	<p style="text-align: center;"><i>9-08 2022</i></p> <p style="text-align: center;">'22 DEC -7 18:15</p> <p style="text-align: center; font-size: small;">STATE OF ILLINOIS DOH - CHICAGO STATE LICENSING</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 #4 – No documented evidence of a current tuberculosis clearance by a physician or APRN.</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 style="text-align: center;"><i>My substitute caregivers will double check to make sure the documentation is on file. PCG</i></p>	<p style="text-align: center;">22 DEC -7 18:15</p> <p style="text-align: center;">STATE OF HAWAII DHE-8102A STATE LICENSING</p>

Licensee's/Administrator's Signature: Irene B. Alipio
Print Name: IRENEA B. ALIPIO
Date: 12-05-2022

STATE OF HAWAII
DHF-CHCA
STATE LICENSING

22 DEC -7 A8:15