Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Jennifer Galicinao RN ARCH	**CHAPTER 100.1**
Address: **94-431 Kahualena Street, Waipahu, Hawaii 96797**	**Inspection Date: February 7, 2022 Initial**

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
☒	§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. **FINDINGS** Household member (HM) #1 - No physical examination. **Submit a copy with the plan of correction (POC).**	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Deficiency corrected. attached copy of Physical exam.	2/15/22

	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** Household member (HM) #1 - No physical examination. **Submit a copy with the plan of correction (POC).**	**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 use spread sheet for PE/TB clearances. Check monthly for expiration dates and due forms. - Remind household members and care givers of due dates and make appts as appropriate prior to due dates - Make sure that the copies of PE is received.	5/4/2022

STATE OF HAWAII
DEPT. OF HUMAN SERVICES

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	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** Primary care giver (PCG), substitute care giver (SCG) and HM #2 - No documented evidence of positive TB clearance. **Submit a copy for each with the POC.**	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** attached copy of documented ~~TB~~ clearance as evidence of correction.	3/22/22

	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** Primary care giver (PCG), substitute care giver (SCG) and HM #2 - No documented evidence of positive TB clearance. **Submit a copy for each with the POC.**	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** - For Caregivers and house hold members with h/o ⊕PPD. I will obtain Documentation of ⊕ TB test with follow-up of chest X-Ray.	5/4/2022

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; **FINDINGS** PCG and SCG - No first aid certification. **Submit a copy for each with the POC.**	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Deficiency corrected. Copies of the first aid certification will be attached PCG folder and will be readily available to nurse consultant upon visit and request. Expiration dates will be reviewed in a timely manner. - Copies attached	March 22, 2022

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; **FINDINGS** PCG and SCG - No first aid certification. **Submit a copy for each with the POC.**	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** attached copies of CPR/first aid.. Check spread sheet for expiration dates. -make sure copies of clearances and certification are in the binder. all forms are physically in the PCG binder.	5/4/2022

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STATE OF HAWAII
OCCP-UNIT
STATE LICENSING

Licensee's/Administrator's Signature: Jennifer Galicinao

Print Name: Jennifer Galicinao

Date: March 22, 2022

Licensee's/Administrator's Signature: Jennifer Galicinao

Print Name: Jennifer Galicinao

Date: 5/4/2022