Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Acnam's Care Home, LLC	CHAPTER 100.1
Address: 2467 North School Street, Honolulu, Hawaii 96819	Inspection Date: April 5, 2023 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.

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	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** Substitute care giver #2, Substitute care giver #3: No documented evidence of Fieldprint background check.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Appointment has been scheduled for SCG #2 + 3 Appointment dates are 5/11/23. - Results received for SCG #2 + #3 on 5/22/23. Filed + documented.	5/5/23 completed + verified 6/20/23

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	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** Substitute care giver #1: No documented evidence of annual physical evaluation.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes corrected on. 5/5/23 Document obtaind from PCP physical exam form for SCG#1 is now records	5/5/23

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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. **<u>FINDINGS</u>** Substitute care giver #1: No documented evidence of annual tuberculosis clearance.	**PART 1** **<u>DID YOU CORRECT THE DEFICIENCY?</u>** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, corrected on 5/5/23 Documed obtained from PCP TB clearance for SCG #1 is now in record	completed/verifed 6/20/23 STATE OF HAWAII DOH-OHCA STATE LICENSING 23 JUL -6 A8 :05

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Licensee's/Administrator's Signature: ______________________

Print Name: Castra Acnam

Date: 6/24/23

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