

Office of Health Care Assurance

State Licensing Section

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Juanita's	CHAPTER 100.1
Address: 1902 Palamoi Street, Pearl City, Hawaii 96782	Inspection Date: June 20, 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) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

STATE OF HAWAII  
DHHS-ORCA  
STATE LICENSING

23  
AUG 21 12:47

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-3 <u>Licensing</u> . (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;  <u>FINDINGS</u> Primary Caregiver, Substitute Caregiver #1,2 – Valid Fieldprint clearance unavailable for review. Submit a copy with plan of correction.	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>Fieldprint clearance of my SCG #1, 2 including myself are done and result is clear.</i></p> <p style="text-align: center;"><i>Enclosed a copy</i></p> <div style="text-align: right; font-size: small;">             STATE OF HAWAII              DDM-ORCA              STATE LICENSING           </div>	<p style="text-align: right;"><i>7/11/23</i></p> <p style="text-align: right;"><b>23 AUG 21 12:47</b></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><b><u>FINDINGS</u></b>  Primary Caregiver, Substitute Caregiver #1,2 – Valid Fieldprint clearance unavailable for review. Submit a copy with plan of correction.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>I will write a week before actual due date on the calendar or my folder to remind me to obtain a field print clearances of my #1+2 SCG including myself.</i></p> <p style="text-align: right; font-size: small;">STATE OF HAWAII  DOH-DHCA  STATE LICENSING</p>	<p style="text-align: center;">7/11/23</p> <p style="text-align: center;"><b>23 AUG 21 11:24:47</b></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(2)            Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident;</p> <p><b><u>FINDINGS</u></b>            Resident #1 – All medication orders not reflected in the care plan with the exception of the following:</p> <ul style="list-style-type: none"> <li>• Amlodipine 5mg – 1.5 tabs daily</li> <li>• Senna 8.6mg – 2 tabs PO every evening for constipation. Hold for loose stools.</li> </ul> <p>Submit a copy of updated care plan with plan of correction.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>The RNEM corrected this deficiency by adding the ordered meds. to the care plan. See attached.</i></p> <p style="text-align: right; font-size: small;">STATE OF HAWAII            DHHS            STATE LICENSING</p>	<p style="text-align: center;"><i>9/3/23</i></p> <p style="text-align: center;">23 SEP 18 P 1:40</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(2)            Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident;</p> <p><b><u>FINDINGS</u></b>            Resident #1 – Care plan does not reflect the following health issues:</p> <ul style="list-style-type: none"> <li>• Osteoporosis as evidenced by confirmed diagnosis and prescribed calcium supplement</li> <li>• Risk for nutrition deficit as evidenced by prescribed calcium and vitamin E supplement</li> <li>• Glaucoma as evidenced by confirmed diagnosis and multiple prescribed medications</li> <li>• Risk for constipation as evidenced by confirmed diagnosis and prescribed medications</li> </ul> <p>Submit a copy of updated care plan with plan of correction.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>The RNCM updated the care plan by opening up new problem statements, interventions, and goals reflecting the following health issues:</i></p> <ol style="list-style-type: none"> <li>1) <i>Osteoporosis</i></li> <li>2) <i>Risk for nutrition deficit</i></li> <li>3) <i>Glaucoma</i></li> <li>4) <i>Risk for constipation</i></li> </ol>	<p style="text-align: right;"><i>9/8/23</i></p> <p style="text-align: right;">23 SEP 18 P1:40</p> <p style="text-align: right; font-size: small;">STATE OF ILLINOIS        BOARD OF NURSING        STATE LICENSING</p>

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Licensee's/Administrator's Signature: Juanita Fajardo

Print Name: Juanita Fajardo

Date: 8/15/23

STATE OF HAWAII  
DGH-DHCA  
STATE LICENSING

23 AUG 21 12:45



Licensee's/Administrator's Signature: Juanita Fajardo

Print Name: Juanita Fajardo

Date: 9/3/23

23 SEP 18 P1:40  
STATE OF MARYLAND  
DH-QMCA  
STATE LICENSING