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Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: 3 J's	**CHAPTER 100.1**
Address: **1624 Perry Street, Honolulu, Hawaii 96819**	**Inspection Date: April 24, 2024 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 PER HAR 11-100.1-3(e)(2). IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

FAILURE TO CORRECT CITED DEFICIENCIES AS PER THE PLAN OF CORRECTION COULD RESULT IN REFUSAL TO RENEW YOUR LICENSE PER HAR 11-100.1-3(e)(3).

	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 1 ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** Substitute Care Giver (SCG) #1 – No documented evidence of a current annual tuberculosis clearance by a physician or advance practice registered nurse (APRN) on file.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** -Annual TB test Completed on 04/26/24. See attached form.	APRIL 26, 2024 '24 MAY -2 A10:08

	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** Substitute Care Giver (SCG) #1 – No documented evidence of a current annual tuberculosis clearance by a physician or advance practice registered nurse (APRN) on file.	**PART 2** **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 shall verified the TB clearances of my substitute in a monthly basis to ensure the accuracy and done before the due date. And before one month of my inspection I shall verify every week to ensure the TB test doesn't expired, and reminder NOTE will be posted in front of the binder. [signature]	APRIL 26, 24

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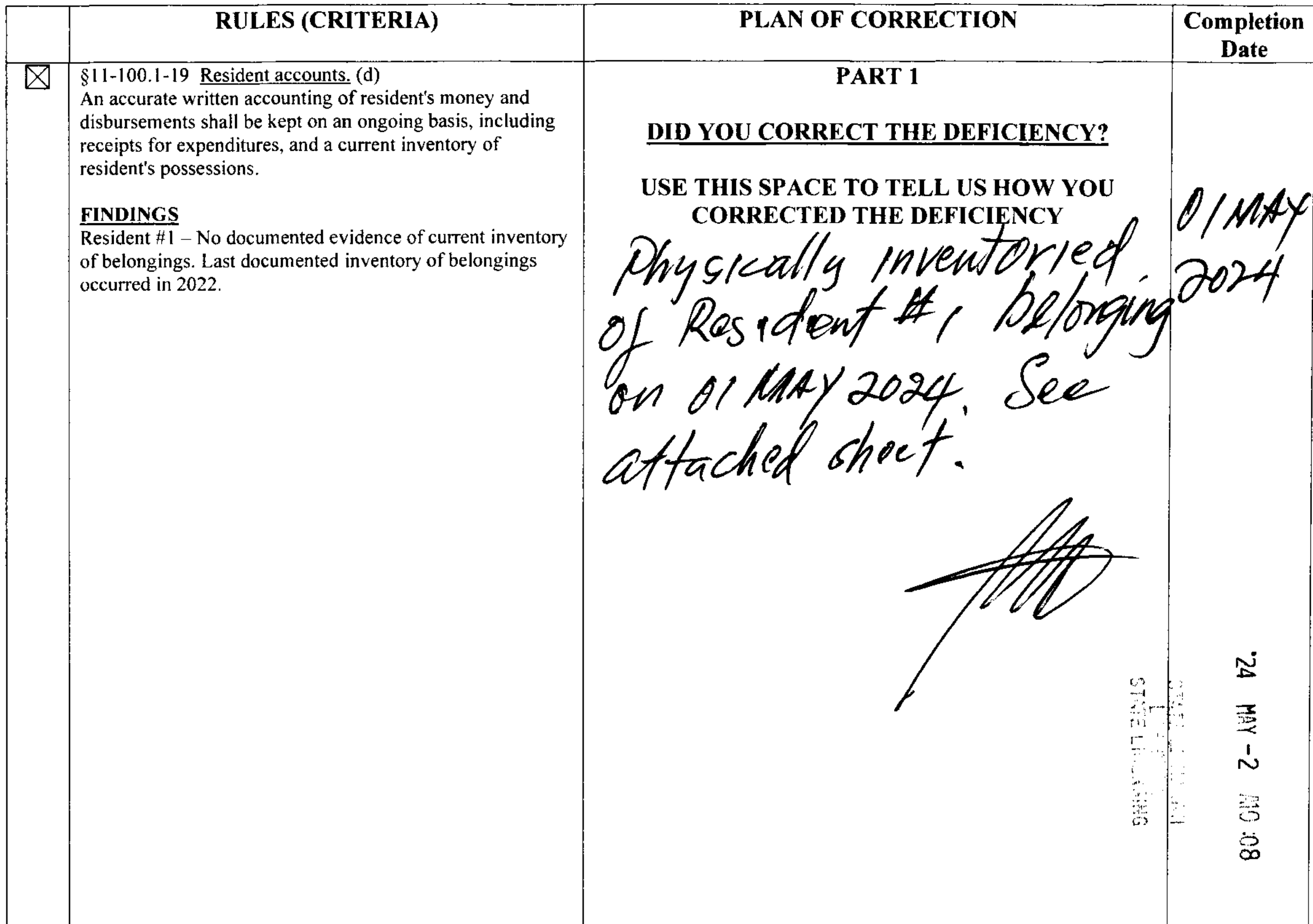

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-19 Resident accounts. (d) An accurate written accounting of resident's money and disbursements shall be kept on an ongoing basis, including receipts for expenditures, and a current inventory of resident's possessions. **FINDINGS** Resident #1 – No documented evidence of current inventory of belongings. Last documented inventory of belongings occurred in 2022.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Physically inventoried of Resident #1 belonging on 01 MAY 2024. See attached sheet. [signature]	01 MAY 2024

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-19 Resident accounts. (d) An accurate written accounting of resident's money and disbursements shall be kept on an ongoing basis, including receipts for expenditures, and a current inventory of resident's possessions. **FINDINGS** Resident #1 – No documented evidence of current inventory of belongings. Last documented inventory of belongings occurred in 2022.	**PART 2** **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 resident clothing will be inventoried once a year. One month before my annual inspection I will double check the Inventories has been done, or make a reminder Note in front of the resident's binder 3 months before annual inspection.	01 MAY 2024 '24 MAY -2 AM 10:08

Licensee's/Administrator's Signature: [signature]

Print Name: Geronimo Castillo

Date: 01 MAY 2024

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