

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name:</b> Martha's	<b>CHAPTER 100.1</b>
<b>Address:</b> 516 Ihe Street, Honolulu, Hawaii 96817	<b>Inspection Date:</b> March 28, 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).**

STATE LICENSING

24 OCT-2 PM 1:47

	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>  Substitute Care Giver (SCG) #2, House Hold Member (HHM) #1, and HHM #2 – No documented evidence that aforementioned care givers/adults have no prior felony or abuse convictions in a court of law.</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>It was done on the 3/11/24.</i></p> <p style="text-align: right; font-size: small;">STATE LICENSING</p>	<p style="text-align: center;"><i>3/11/24</i></p> <p style="text-align: center;">24 OCT -2 AM 2:7</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>  SCG #2, HHM #1, and HHM #2 – No documented evidence that aforementioned care givers/adults have no prior felony or abuse convictions in a court of law.</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 style="text-align: center;"><i>I will have my substitute care giver to do do do do do check it is done.</i></p> <p style="text-align: right; font-size: small;">STATE LICENSING</p>	<p style="text-align: right;">24 OCT -2 AM 1:47</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p><b>FINDINGS</b>  SCG #2, HHM #1, HHM #2, HHM #3, and HHM #4 – No documented evidence of a current annual physical examination clearance signed by a physician or advanced practice registered nurse (APRN) on file.</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>SCG #2 HHM #1 HHM #2 HHM #3 and HHM #4. All their annual physical examination clearance was done  #1 - 4/1/2024 and if it is file in policy folder.  #2 - 4/1/2024  #3 - 4/1/2024 was pick up from school + file in policy folder  #4 - 4/1/2024</p>	<p>4/8/24</p> <p style="text-align: right;">K. T. Annabolo  CHT</p> <p style="text-align: right;">24 APR 17 P 1:07</p> <p style="text-align: center;">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><b>FINDINGS</b> SCG #2 – No documented evidence of a current annual tuberculosis clearance signed by physician or APRN.</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>My future plan - My future plan to make sure it is done on time, my substitute car gives will double check, it is done on time. Here is a copy of her certificate of her <del>car</del> TB clearance is attached.</i></p>	<p><i>5/13/24</i></p> <p><i>MTauraloh</i> <i>LHO</i></p> <p style="text-align: right;">24 MAY 17 P2:29</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><b>FINDINGS</b> SCG #2 – No documented evidence of a current annual tuberculosis clearance signed by physician or APRN.</p>	<p style="text-align: center;">PART 1</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>She picked up from the Dr office together to the physical Exam + I file in my policy folder.</i></p>	<p style="text-align: right;"><i>4/8/24</i></p> <p style="text-align: right;"><i>R. Taunton CEO.</i></p> <p style="text-align: right;">24 APR 17 P 1:07</p> <p style="text-align: right; font-size: small;">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><b>FINDINGS</b> SCG #2 – No documented evidence of a current annual tuberculosis clearance signed by physician or APRN.</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>My future plan - My future plan to make sure it is done on time &amp; give my substitute care giver with double check, it is done on time. Here is a copy of her certificate of her TB clearance is attached.</i></p>	<p><i>5/13/24</i></p> <p><i>M. J. ...</i></p> <p><i>CHD</i></p> <p style="text-align: right;">24 MAY 17 P2:29</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p><b>FINDINGS</b> SCG #2 – No documented evidence of a current First Aid certification on file.</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>I made an appointment to take the class on 4/25/24 and it was done.</i></p> <p><i>I made a reminder note + put in front of my desk.</i></p> <p><i>My substitute care giver double checks to make sure it is done time.</i></p>	<p style="text-align: right;">24 MAY 17 02:29</p>



	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p><b>FINDINGS</b> SCG #2 - No documented evidence of a current First Aid certification on file.</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>My substitute care giver will double check to make sure is done.</i></p> <p><i>The certificate, by CPR + first first aid is attached M Tamalaki</i></p> <p style="text-align: right;"><i>CHD</i></p>	<p><i>5/13/24</i></p> <p style="text-align: center;">24 MAY 17 P 2:29</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:</p> <p>Be currently certified in cardiopulmonary resuscitation;</p> <p><b>FINDINGS</b> SCG #2 – No documented evidence of a cardiopulmonary resuscitation certification on file.</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>- I make the appointment to take on 6/10 &amp; 6/14 and it was done.</i> <i>- I made a reminder note in front on my desk.</i></p>	<p><i>6/13/24</i></p> <p style="text-align: right;"><i>M. Taunado</i> <i>CPO</i></p> <p style="text-align: center;">24 MAY 17 P 2:29</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:</p> <p>Be currently certified in cardiopulmonary resuscitation;</p> <p><b><u>FINDINGS</u></b> SCG #2 – No documented evidence of a cardiopulmonary resuscitation certification on file.</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>My future plan - Make sure it is done on time. My substitute care giver checked it is done. The certificate is attached.</i></p>	<p><i>5/19/24</i></p> <p style="text-align: right;">24 MAY 17 P2:28</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 <u>Records and reports</u> , (b)(1) During residence, records shall include:  Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;  <u>FINDINGS</u> Resident #1 – No documented evidence of a current tuberculosis clearance from a physician or APRN.	<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><i>a copy of her TB clearance was picked from dialysis place + file in my policy folder.</i></p>	<p><i>4/8/24</i></p> <p><i>M. Tando</i> <i>CEO</i></p> <p style="text-align: center;">24 APR 17 P 1:05</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:  Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;  <u>FINDINGS</u> Resident #1 – No documented evidence of a current tuberculosis clearance from a physician or APRN.	<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>My future plan - Make a reminder note + place in front of my desk.</i></p> <p><i>- My substitute care give can double check if is done.</i></p>	<p style="text-align: right;"><i>4/3/24</i></p> <p style="text-align: right;"><i>M. Tavello</i> <i>CEO</i></p> <p style="text-align: center;">STATE LICENSING</p> <p style="text-align: right;">24 APR 17 P 1:05</p>

Licensee's/Administrator's Signature: Maata Faumalolo

Print Name: Maata Faumalolo

Date: 9/30/24

Licensee's/Administrator's Signature: Maata Faumalolo

Print Name: Maata Faumalolo

Date: 5/14/24

Licensee's/Administrator's Signature

Maata Faumalolo

Print Name

Maata Faumalolo

Date

4/12/24

STATE  
LICENSING

24 OCT -2 AM 1:47