

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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| Facility's Name: Baybayan, Rosita | CHAPTER 100.1 |
| Address: 91-810 Haiamu Street, Ewa Beach, Hawaii 96706 | Inspection Date: August 20, 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 |
|-------------------------------------|---|--|--|
| <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><u>FINDINGS</u> Primary Care Giver (PCG) & Substitute Care Giver (SCG) #1 – No documented evidence of a current annual physical examination clearance by a physician or advanced practice registered nurse (APRN) on file.</p> | <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>Primary Care Giver (PCG) & Substitute Care Giver (SCG) physical examination have been corrected and completed on 9/5/2024</p> | <p style="text-align: right;">74 187 - 11</p> <p style="text-align: right;">9/5/2024</p> |

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date: 11 |
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| <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><u>FINDINGS</u> PCG & SCG #1 – No documented evidence of a current annual physical examination clearance by a physician or APRN on file.</p> | <p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Primary Care Giver (PCG) & Substitute Care Giver (SCG) will have their Physical Examination completed and placed in file prior to inspection.</p> <p><i>We Double check EPR UPR by 6 months,</i></p> | <p style="text-align: right;">9/15/2024</p> |

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
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| <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><u>FINDINGS</u> PCG & SCG #1 – No documented evidence of a current annual tuberculosis clearance by a physician or APRN on file.</p> | <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>PCG & SCG Annual Tuberculosis clearance test was completed by a Physician or APRN on 9/5/2024.</p> | <p style="text-align: right;">24 NOV -6 11</p> <p style="text-align: right; font-size: 1.2em;">9/5/2024</p> |

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| <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><u>FINDINGS</u> PCG & SCG #1 – No documented evidence of a current annual tuberculosis clearance by a physician or APRN on file.</p> | <p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Completed Annual Tuberculosis test on PCG & SCG will be placed on file prior to inspection, avoiding this discrepancy. <i>We double check every 6 months.</i></p> | <p>'24 NOV -6 10:11</p> <p><i>9/5/2024</i></p> |

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|-------------------------------------|---|--|-------------------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Physician ordered “Raloxifine 60mg PO 1 tablet daily.” Medication not available in facility for resident use.</p> | <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>The Physician ordered "Raloxifine 60mg PO1 daily tablet!" Picked up and medication made available for resident use on 8/21/24. Deficiency corrected.</p> | <p>24 NOV -6 11:11</p> <p>STATE</p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications</u>. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Physician ordered “Raloxifene 60mg PO 1 tablet daily.” Medication not available in facility for resident use.</p> | <p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>The PCG & SCG will insure this medication will be ordered ample time before running out. Medication will be available for the resident all times.</p> <p><i>We double check every month.</i></p> | <p style="text-align: right;">24 NOV -6 PM:11</p> <p style="text-align: right;">8/21/24</p> |

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><u>FINDINGS</u> Resident #2 – No documented evidence of current annual physical examination clearance signed by a physician or APRN on file.</p> | <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>The annual physical examination was completed on 10/4/24. Deficiency corrected.</p> | <p style="text-align: right;">'24 NOV -6 10/4/24</p> |

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Licensee's/Administrator's Signature: Rosita Baybayan

Print Name: ROSITA L. BAYBAYAN

Date: Oct 31, 2024

24 NOV -6 PM:11
STATE LICENSES