

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 5, 2026 Relicensing Inspection

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.

RULE (CRITERIA)	PLAN OF CORRECTION	Completion Date
<p>§11-100.1-15 Medications. (g)</p> <p>All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year.</p> <p><u>FINDINGS:</u></p> <p>Resident #1 – No evidence that medication orders for the resident is reviewed and signed by a physician every four (4) months. Last medication orders were reviewed and signed on 07/03/2025.</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>	

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RULE (CRITERIA)	PLAN OF CORRECTION	Completion Date
<p>§11-100.1-17 Records and reports. (a)(1)</p> <p>The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Documentation of primary care giver's assessment of resident upon admission;</p> <p><u>FINDINGS:</u></p> <p>Resident #2 – No evidence of a current Primary Care Giver admission assessment for the resident.</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>	

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<p>§11-100.1-17 Records and reports. (f)(4)</p> <p>General rules regarding records: All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency.</p> <p><u>FINDINGS:</u></p> <p>Resident #1 – Current level of care evaluation and annual physical examination both dated 07/03/2025, stated that the resident is “ARCH” level of care. However, resident is ICF or expanded level of care.</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>	

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RULE (CRITERIA)	PLAN OF CORRECTION	Completion Date
<p>§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(2)(D)</p> <p>Residents' rights and responsibilities: Each resident shall: Physical restraints may only be used in an emergency when necessary to protect the resident from injury to self or to others. In such a situation the resident's physician or APRN shall be notified immediately to obtain an assessment for least restrictive alternatives to restraint use. If restraint use is determined to be necessary, written orders shall be obtained from the resident's physician or APRN indicating the form of restraint to be used, the length of time restraint shall be applied, the frequency of use and the alternative care that can be provided to the resident. If a less restrictive alternative to restraint exists, it must be used in lieu of the restraint. The resident's family, legal guardian, surrogate or representative, and case manager shall be notified if no alternative to restraint exists and a written consent shall be obtained for restraint use. The restraint use shall be in compliance with the Type I ARCH's written policy, as approved by the department;</p> <p><u>FINDINGS:</u></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>	

Resident #1 – No evidence of a written consent for the use of lap tray and vest restraints		
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Licensee's/Administrator's Signature:

Print Name:

Date: