Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Tender Loving Care	**CHAPTER 100.1**
Address: **94-1227 Kahuanui Street, Waipahu, Hawaii 96797**	**Inspection Date: December 10, 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
☒	§11-100.1-8 Primary care giver qualifications. (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall: Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current; **FINDINGS** Primary Care Giver (PCG) – No documented evidence of six (6) continuing education hours completed within the past twelve (12) months on file.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Completed six hours of training. I will provide documentation.	1/13/25

STATE FILM NO.

25 JAN 16 P2:47

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-8 Primary care giver qualifications. (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall: Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current; **FINDINGS** PCG – No documented evidence of six (6) continuing education hours completed within the past twelve (12) months 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 will attend six hours of training. My substitute caregiver will double check every six months to make sure training on file.	1/13/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** PCG – No documented evidence of a current annual physical examination clearance from a physician or advanced practice registered nurse (APRN) on file. I had Doctor sign Physical examinations	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I had Doctor sign Physical examination. Place in the file.	1/13/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** PCG – No documented evidence of a current annual physical examination clearance from a physician or advanced 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 will have Doctor sign of physical exam. My substitute caregiver will double check every six month to make sure physical exam is on file.	1/25/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 Food sanitation. (a) All food shall be procured, stored, prepared and served under sanitary conditions. **FINDINGS** Observed refrigerator door shelf with dead cockroaches in a sticky liquid substance.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I clean refrigerator door of cockroaches and sticky liquid substance.	1/13/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 Food sanitation. (a) All food shall be procured, stored, prepared and served under sanitary conditions. **FINDINGS** Observed refrigerator door shelf with dead cockroaches in a sticky liquid substance.	**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 clean refrigerator so there is no cockroches or liquid substance. My substitute caregiver will double check every six month to make sure refrigirator is clean.	1/13/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (g) 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. **FINDINGS** Resident #1 – Physician ordered "Betamethasone 0.05% lotion," "Hydrocortisone 2.5% ointment," "Ammonium lactate 12% lotion," and "Selenium sulfide 2.5% shampoo." No documented evidence of a physician order for the aforementioned medications on file.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Doctor sign the order for the medication on file.	1/13/20

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (g) 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. **FINDINGS** Resident #1 – Physician ordered "Betamethasone 0.05% lotion," "Hydrocortisone 2.5% ointment," "Ammonium lactate 12% lotion," and "Selenium sulfide 2.5% shampoo." No documented evidence of a physician order for the aforementioned medications 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?** I will make sure the Doctor sign orders for all medication. My substate caregiver will double check every six month to make sure medication order is file.	1/13/25

	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 a current inventory of belongings on file.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** completed all inventory of residents belongings	1/13/25 '25 JAN 16 P3:43

	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 a current inventory of belongings 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?** I will complete inventory of residents belongings every year. My substitute caregiver will double check every six month to make sure inventory is file.	1/13/25

Licensee's/Administrator's Signature: Jovita Eton

Print Name: Jovita Eton

Date: 1/13/25