

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Castanaga, Imelda (E-ARCH)	CHAPTER 100.1
Address: 94-972 Lumimoe Street, Waipahu, Hawaii, 96797	Inspection Date: August 29, 2022 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. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

STATE LICENSING SECTION
STATE OF HAWAII
NOV 22 08:16

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 Licensing. (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>FINDINGS Substitute care giver #1,#2: No documented evidence of Fieldprint background check.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u> <i>yes</i></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Substitute #1 Finger printing was obtained 7/20/20 + 8/20/21 and now on file.</i></p> <p><i>Substitute #2 Finger printing was obtained on 2/21/22 and now on file.</i></p>	<p><i>9/10/22</i></p> <p><i>11/10/22</i></p> <p style="text-align: center;">22 NOV 22 4:8:17</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 Licensing. (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><u>FINDINGS</u> Substitute care giver #1,#2: No documented evidence of Fieldprint background check.</p>	<p style="text-align: center;">PLAN OF CORRECTION</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 style="text-align: center;"><i>I will make a reminder note when to recheck field print background check.</i></p>	<p style="text-align: right;"><i>11/10/22</i></p> <p style="text-align: right;">22 NOV 22 4 8:17</p> <p style="text-align: right; font-size: small;">STATE OF CONNECTICUT DOR-ARCH STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.</p> <p>FINDINGS Resident #1: Multivitamin bottle in medication cabinet, no current order for multivitamin.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u> <i>yes</i></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>Medication was secured right away.</i></p>	<p style="text-align: center;"><i>8/29/22</i></p> <p style="text-align: center;">22 NOV 22 08:17</p> <p style="text-align: center;">STATE OF HAWAII DHS-CPS-21 STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.</p> <p><u>FINDINGS</u> Resident #1: Multivitamin bottle in medication cabinet, no current order for multivitamin.</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><i>I will make a note on my 11/10/22 calendar whenever medication is discontinued and discard it right away.</i></p>	<p style="text-align: right;">22 NOV 22 08:17</p>

STATE OF PENNSYLVANIA
DEPARTMENT OF
STATE LICENSING

Licensee's/Administrator's Signature: Imelda B. Castanaga

Print Name: IMELDA CASTANAGA

Date: 11/10/22