Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Tabora's (ARCH/E-ARCH)	**CHAPTER 100.1**
Address: **94-970 Lumioahu Street, Waipahu, Hawaii 96797**	**Inspection Date: February 14, 2023 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) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-3 Licensing. (b)(1)(I) Application. 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: 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; **FINDINGS** Primary Care Giver, Substitute Care Giver (SCG) #1, SCG #2 – No current documented evidence stating aforementioned care givers have no prior felony or abuse convictions in a court of law. Please provide a copy of the Fieldprint results as evidence of completion.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Primary caregiver and substitute caregiver no. 1 did finger printing on 2/20/23. Copy of result will be attach to folder once it is received. Substitute caregiver no. 2 result submitted	2/20/23

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (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; **FINDINGS** Resident #1 – No current annual tuberculosis clearance. Last TB clearance on file dated 6/23/21. Please attach a copy of resident's current tuberculosis assessment as evidence of completion.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Resident no. 1 was brought to Kaiser Clinic on 2/27/23 for tuberculosis clearance. Results was put on her record and copy attach	2/27/23

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STATE OF HAWAII
DEPARTMENT OF
STATE LICENSING

Licensee's/Administrator's Signature: Lourdes Tabora

Print Name: LOWRDES TABORA

Date: 3/1/2023