

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Garcia Care Home	CHAPTER 100.1
Address: 99-568 Huakanu Street, Hawaii, 96701	Inspection Date: February 16, 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) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

STATE LICENSING
HAWAII
MAY 31 09:16 '23

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (d) The Type I ARCH shall only admit residents at appropriate levels of care. The capacity of the Type I ARCH shall also be limited by this chapter, chapter 321, HRS, and as determined by the department.</p> <p><u>FINDINGS</u> Resident #2: Resident certified as “intermediate care facility” on 9/2/22. Care home only licensed for ARCH level of care residents.</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>Resident # 2 is now certified as ARCH level of care. clarify with Physician on 3/23/2023</p> <p style="text-align: right; font-size: small;">STATE LICENSING DOR MAY 31 10 16 AM '23</p>	<p>5-30-23</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (d) The Type I ARCH shall only admit residents at appropriate levels of care. The capacity of the Type I ARCH shall also be limited by this chapter, chapter 321, HRS, and as determined by the department.</p> <p><u>FINDINGS</u> Resident #2: Resident certified as "intermediate care facility" on 9/2/22. Care home only licensed for ARCH level of care residents.</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 will make a reminder in my personal note to verify any new order after MD visit. To ensure order meet capacity of care home.</p> <p style="text-align: right;">STATE OF HAWAII DEPT. OF HEALTH STATE LICENSING MAY 31 09:16</p>	<p>5-30-2023</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>. (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> House hold member #1: 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></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>HHM # 1 was obtain Field Print background check on 4/3/23 it is now on file. 5-3 89</p> <div style="text-align: right; margin-top: 200px;"> STATE OF MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES DIVISION OF LICENSING 23 MAY 31 AM 17 </div>	<p>5-30-2023</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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Licensee's/Administrator's Signature: Fe A. Garcia

Print Name: Fe A. Garcia

Date: 5-30-2023

STATE OF HAWAII
DEPARTMENT OF
STATE LICENSING

23 MAY 31 09:17