Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Santos, Norma (ARCH)	CHAPTER 100.1
Address: 4240 Keaka Drive, Honolulu, Hawaii 96818	Inspection Date: October 13, 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.

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 Caregiver (PCG), Substitute Caregiver (SCG) #1-3 — Current Fieldprint clearance unavailable for review. Submit a copy with plan of correction.	PLAN OF CORRECTION PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	-

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
Application. In order to obte director upon provide any in demonstrate the ARCH have noted following shalts. Documented engiver, family in ARCH that has and substitute convictions in FINDINGS. Primary Caregory.	cicensing. (b)(1)(I) ain a license, the applicant shall apply to the forms provided by the department and shall formation required by the department to nat the applicant and the ARCH or expanded net all of the requirements of this chapter. The l accompany the application: Evidence stating that the licensee, primary care members living in the ARCH or expanded we access to the ARCH or expanded ARCH, care givers have no prior felony or abuse a court of law; Eviver (PCG), Substitute Caregiver (SCG) #1-3 deprint clearance unavailable for review. With plan of correction.	PART 2 FUTURE PLAN USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	-

RU	ULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
(a) All individuals who to residents in the T evidence that they h to their first contact and thereafter shall certify that they are FINDINGS	either reside or provide care or services ype I ARCH, shall have documented have been examined by a physician prior with the residents of the Type I ARCH, be examined by a physician annually, to free of infectious diseases. Chysical exam unavailable for review. plan of correction.	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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 SCG #2 – Current physical exam unavailable for review. Submit a copy with plan of correction.	PART 2 FUTURE PLAN USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. FINDINGS SCG #1,2 – Initial tuberculosis clearance unavailable for review. Submit a copy with plan of correction.	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
RULES (CRITERIA) §11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; FINDINGS SCG #2 – Valid first aid certification unavailable for review. Submit a copy with plan of correction.	PLAN OF CORRECTION PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	_

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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\$\frac{\{\sqrt{11-100.1-9 Personnel, staffing and family requirements.}}{(e)(4)}\$ The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. FINDINGS PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
SCG #1 – Documented evidence of PCG training completed unavailable for review. Submit a copy with plan of correction.	(e)(4) The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. FINDINGS SCG #1 – Documented evidence of PCG training completed unavailable for review.	DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU	Date

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Licensee's/Administrator's Signature: _	
Print Name:	
Date:	