

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.

STATE OF HAWAII
DEPARTMENT OF HEALTH
STATE LICENSING SECTION

24 JAN 11 PM 2:34

	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 APCH 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> Primary Caregiver (PCG), Substitute Caregiver (SCG) #1-3 – Current Fieldprint clearance unavailable for review.</p> <p>Submit a copy with plan of correction.</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>Fieldprint clearance for Primary Caregiver (PCG) was completed on <u>11/16/2023</u>.</p> <p>Fieldprint clearance for Substitute Caregiver (SCG #1) was completed on <u>11/16/2023</u>.</p> <p>Fieldprint clearance for Substitute Caregiver (SCG #2) was completed on <u>11/20/2023</u>.</p> <p>Fieldprint clearance for Substitute Caregiver (SCG #3) was completed on <u>11/1/2023</u>.</p> <p>(Copy of results sent to DOH)</p>	<p>11/16/23</p> <p>11/16/23</p> <p>11/20/23</p> <p>11/1/23</p> <p>24 JAN 11 PM 34</p>

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
STATE LICENSING

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<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> Primary Caregiver (PCG), Substitute Caregiver (SCG) #1-3 – Current Fieldprint clearance unavailable for review.</p> <p>Submit a copy with 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>In the future, Fieldprint clearances for the Primary Caregiver (PCG) and Substitute Caregivers (SCG) will be completed prior to annual inspections and will be made available for review. A checklist will be created to ensure all requirements are met.</p>	<p style="text-align: right;">STATE OF MARYLAND DEPARTMENT OF LICENSING STATE DIRECTOR'S OFFICE</p> <p style="text-align: right;">24 JAN 11 P12:34</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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.</p> <p><u>FINDINGS</u> SCG #2 – Current physical exam unavailable for review.</p> <p>Submit a copy with plan of correction.</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>Physical examination for Substitute Caregiver #2 was completed on <u>02/15/2023</u>.</p> <p>(Attached is a copy of SCG #2 physical examination)</p>	<p style="text-align: center;">2/15/23</p> <p style="text-align: right;"> <small>STATE OF HAWAII DEPARTMENT OF HEALTH STATE LINCENSING</small> 24 JAN 11 PM 2:34 </p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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.</p> <p><u>FINDINGS</u> SCG #2 – Current physical exam unavailable for review.</p> <p>Submit a copy with 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>In the future, physical examinations for the Primary Caregiver (PCG) and Substitute Caregivers (SCG) will be completed prior to annual inspections and will be made available for review. A checklist will be created to ensure all requirements are met.</p>	<p style="text-align: right;">STATE OF MICHIGAN DEPARTMENT OF HUMAN SERVICES STATE LIAISON</p> <p style="text-align: right;">24 JAN 11 12:34</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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.</p> <p><u>FINDINGS</u> SCG #1,2 – Initial tuberculosis clearance unavailable for review.</p> <p>Submit a copy with plan of correction.</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>Tuberculosis clearance for Substitute Caregiver #1 was completed on <u>8/28/2023</u>.</p> <p>Tuberculosis clearance for Substitute Caregiver #2 was completed on <u>02/15/2023</u>.</p> <p>(Attached is a copy of TB clearances for SCG #1 and #2)</p>	<p>8/28/23</p> <p>2/15/23</p> <p>24 JAN 11 PM 12 34</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">STATE ECONOMIC DEVELOPMENT</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p><u>FINDINGS</u> SCG #2 – Valid first aid certification unavailable for review.</p> <p>Submit a copy with plan of correction.</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>First aid certification for Substitute Caregiver #2 was completed on <u>4/12/2023</u>.</p> <p>(Attached is a copy of SCG #2 valid first aid certification)</p>	<p style="text-align: center;">4/12/23</p> <p style="text-align: center;">24 JAN 11 P12:34</p> <p style="text-align: center;">STATE OF HAWAII DEPARTMENT OF HEALTH STATE LICENSING</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><u>FINDINGS</u> SCG #1 – Documented evidence of PCG training completed unavailable for review.</p> <p>Submit a copy with plan of correction.</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>Documented evidence of PCG training for Substitute Caregiver #1 was completed on <u>08/25/2023</u>.</p> <p>(Attached is a copy of SCG #1 PCG training)</p>	<p>8/25/23</p> <p style="text-align: right;">24 JAN 11 12:34</p> <p style="text-align: right; font-size: small;">STATE OF HAWAII DEPARTMENT OF HEALTH STATE LICENSING</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><u>FINDINGS</u> SCG #1 – Documented evidence of PCG training completed unavailable for review.</p> <p>Submit a copy with 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>In the future, documented evidence of PCG training for Substitute Caregivers will be completed prior to annual inspections and will be made available for review. A checklist will be created to ensure all requirements are met.</p>	<p style="text-align: right;">24 JAN 11 12:34</p> <p style="text-align: right; font-size: small;">STATE OF ILLINOIS DEPARTMENT OF STATE LICENSING</p>

Licensee's/Administrator's Signature: *Norma Santos*

Print Name: Norma Santos

Date: 12/20/23

STATE OF HAWAII
DEPARTMENT OF
STATE LICENSES

24 JAN 11 PM 12:34