

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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|---|---|
| <b>Facility's Name: Susan Ramos Care Home, LLC</b>            | <b>CHAPTER 100.1</b>                          |
| <b>Address:<br/>94-722 Loaa Street, Waipahu, Hawaii 96797</b> | <b>Inspection Date: April 18, 2023 Annual</b> |

**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 |
|-------------------------------------|---|---|-----------------|
| <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><b><u>FINDINGS</u></b><br/>Household member (HM) #1 – No Fieldprint result.</p> | <p>PART 1</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I HAVE OBTAINED A COPY OF FINGERPRINT FOR MY HOUSEHOLD MEMBER.</p> | <p>4/28/23</p>  |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                            |
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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><b><u>FINDINGS</u></b><br/>Household member (HM) #1 – No Fieldprint result.</p> | <p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p style="text-align: center;">TO PREVENT THIS FROM HAPPENING, I WILL POST IT IN A CALENDAR COUNTER. I WILL CHECK EVERY MONTH AS A REMINDER TO PREVENT FUTURE LAPSE.</p> | <p style="text-align: center;">4/19/23</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date                            |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u><br/>(e)(4)<br/>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><b><u>FINDINGS</u></b><br/>Substitute Care Giver (SCG) #1, #2, #3 -No record that Primary Care Giver (PCG) trained SCG to make prescribed medication available to residents.</p> | <p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I HAVE TRAINED MY CAREGIVER #1, #2, #3 TO MAKE PRESCRIBED MEDICATION AVAILABLE TO RESIDENTS <sup>AND</sup> PUT IT IN MY CARE HOME BINDER. SUBSTITUTE #1, #2 4/19/23.<br/>SUBSTITUTE #3 4/20/23</p> | <p style="text-align: center;">4/19/23</p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u><br/>(e)(4)<br/>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><b>FINDINGS</b><br/>Substitute Care Giver (SCG) #1, #2, #3 -No record that Primary Care Giver (PCG) trained SCG to make prescribed medication available to residents.</p> | <p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>7 IN ORDER FOR THIS NOT TO HAPPEN I WILL CHECK MY SCG TRAINING EVERY FIRST WEEK OF THE MONTH.</p> <p>- I WILL USE SCG checklist to complete medication training.</p> | <p style="text-align: right;">9/13/23</p> <p style="text-align: right;">23 SEP 13 AM 3:38</p> <p style="text-align: right; font-size: small;">STATE OF HAWAII<br/>DOH-616A<br/>STATE LICENSING</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date   |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-14 <u>Food sanitation.</u> (f)<br/>Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.</p> <p><b><u>FINDINGS</u></b><br/>Bottles of bleach were stored in the unlocked cabinet under the kitchen sink. A paddle lock was attached to the cabinet door, but it was not engaged.</p> | <p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>PCC CONNECTED ENSURE THE CABINET UNDER THE SINK IS LOCK WHEN NOT USE.</p> | <p style="text-align: center;">9/13/23</p> <p style="text-align: center;">23 SEP 13 AIO:38</p> <p style="text-align: center;">STATE OF HAWAII<br/>DOH-842CA<br/>STATE LICENSING</p> |

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|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date                             |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications.</u> (a)<br/> All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms.</p> <p><b><u>FINDINGS</u></b><br/> The medication cabinet was not locked upon department arrival. Corrected during inspection.</p> | <p style="text-align: center;">PART 1</p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> | <p style="text-align: center;">12/11/22</p> |



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|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                                    |
|-------------------------------------|---|---|--|
| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications.</u> (m)<br/> All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver.</p> <p><b><u>FINDINGS</u></b><br/> Resident #1 – In medication administration record (MAR), future dates 4/18/2023 pm dose and 4/19/2023 am dose were initialed as Periguard Ointment was administered.</p> | <p style="text-align: center;">PART 1</p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> | <p style="text-align: center;">23 APR 16 11:27</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date   |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications.</u> (m)<br/>All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver.</p> <p><u>FINDINGS</u><br/>Resident #1 – In medication administration record (MAR), future dates 4/18/2023 pm dose and 4/19/2023 am dose were initialed as Periguard Ointment was administered.</p> | <p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>7 ATTACHED IS MY MONTHLY CHART AUDIT TO MAKE SURE THAT MY MAR WAS DONE CORRECTLY.</p> <p>7 I will initial the MAR right after Administration of the medication.</p> | <p style="text-align: right;">9/13/23</p> <p style="text-align: right;">23 SEP 13 AM 0:37</p> <p style="text-align: center;">STATE OF HAWAII<br/>DHHS<br/>STATE LICENSING</p> |

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|  | RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date   |
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| <input checked="checked" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (a)(1)<br/>The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>Documentation of primary care giver's assessment of resident upon admission;</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – Admission assessment form page 1 was not available for department review.</p> | <p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> | <p style="text-align: center;">03</p> <p style="text-align: center;">11</p> <p style="text-align: center;">11</p> <p style="text-align: center;">11</p> |

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|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date                                      |
|-------------------------------------|---|--|--|
| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (f)(3)<br/>General rules regarding records:</p> <p>An area shall be provided for safe and secure storage of resident's records which must be retained in the ARCH for periods prescribed by state law;</p> <p><b><u>FINDINGS</u></b><br/>Residents' binder cabinet was not locked upon department arrival. Corrected during inspection.</p> | <p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> | <p style="text-align: right;">23 MAY 16 AM 11:26</p> |



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|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date   |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (f)(4)<br/>General rules regarding records:</p> <p>All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency.</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – Emergency information sheet not completed.</p> | <p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;">I OBTAINED AND COMPLETED EMERGENCY INFORMATION SHEET AND PLACE IT TO RESIDENT'S BANDER.</p> | <p style="text-align: center;">4/19/23</p> <p style="text-align: center;">23 MAY 16 AM 12:26</p> <p style="text-align: center;">STATE LICENSING</p> |

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|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date   |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (h)(1)<br/>Miscellaneous records:</p> <p>A permanent general register shall be maintained to record all admissions and discharges of residents;</p> <p><b><u>FINDINGS</u></b><br/>"Admitted From" in Permanent Resident Register not recorded for one (1) current resident.</p> | <p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;">7 FORM WAS COMPLETED</p> | <p style="text-align: center;">9/13/23</p> <p style="text-align: center;">23 SEP 13 AM 0:36</p> <p style="text-align: center;">STATE OF HAWAII<br/>DOH-DHCA<br/>STATE LICENSING</p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-23 <u>Physical environment.</u> (p)(5)<br/>Miscellaneous:</p> <p>Signaling devices approved by the department shall be provided for resident's use at the bedside, in bathrooms, toilet rooms, and other areas where residents may be left alone. In Type I ARCHs where the primary care giver and residents do not reside on the same level or when other signaling mechanisms are deemed inadequate, there shall be an electronic signaling system.</p> <p><b><u>FINDINGS</u></b><br/>Signaling devices not working in the bathroom inside the resident bedroom #1 and two (2) bathrooms in the hallway.</p> | <p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I HAVE PROVIDED THE SIGNALING DEVICES INSIDE THE ACCIDENT BATHROOM, THE RESIDENT BEDROOM #1 AND 2 BATHROOMS IN THE HALLWAY. I WILL CHECK EVERYDAY TO ENSURE ITS PROPERLY WORKING.</p> | <p style="text-align: center;">4/19/23</p> <p style="text-align: right;">23<br/>MAY 14 11:20</p> |

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|-------------------------------------|---|--|--|
| <input checked="" type="checkbox"/> | <p>§11-100.1-23 <u>Physical environment.</u> (p)(5)<br/>Miscellaneous:</p> <p>Signaling devices approved by the department shall be provided for resident's use at the bedside, in bathrooms, toilet rooms, and other areas where residents may be left alone. In Type I ARCHs where the primary care giver and residents do not reside on the same level or when other signaling mechanisms are deemed inadequate, there shall be an electronic signaling system.</p> <p><b><u>FINDINGS</u></b><br/>Signaling devices not working in the bathroom inside the resident bedroom #1 and two (2) bathrooms in the hallway.</p> | <p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p style="text-align: center;">IN THE FUTURE I WILL CHECKED EVERYDAY THE EQUIPMENT MAKE SURE ARE IN BOTH CONDITION.</p> | <p style="text-align: right;">4/19/23</p> <p style="text-align: right;">23 APR 16 7:08</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date           |
|-------------------------------------|--|---|---------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-23 <u>Physical environment.</u> (r)<br/>Facilities shall be maintained in accordance with provisions of state and local zoning, building, fire safety and health codes.</p> <p><b><u>FINDINGS</u></b><br/>PCG stated that dishes are rinsed after soaking in bleach solution.</p> | <p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> | <p>23 NOV 15 11:21 PM</p> |

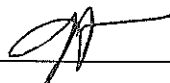


|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date   |
|-------------------------------------|---|---|---|
| <input checked="" type="checkbox"/> | <p>§11-100.1-23 <u>Physical environment.</u> (r)<br/>Facilities shall be maintained in accordance with provisions of state and local zoning, building, fire safety and health codes.</p> <p><b>FINDINGS</b><br/>PCG stated that dishes are rinsed after soaking in bleach solution.</p> | <p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>I THE FUTURE I HAVE TO MAKE SURE THAT I WILL MAKE THE SOAK THE DISHES &amp; UTENSILS IN THE CURRENT BLEACH SOLUTION FOR AT LEAST 1-5 min. AFTER THAT ALL MY DISHES &amp; UTENSILS</p> <p>&gt; I put it how to sanitize the information how to sanitize the dishes in the kitchen.</p> <p>&gt; I train my SCC to be information.</p> | <p style="text-align: center;">9/13/23</p> <p style="text-align: center;">23 SEP 13 AM 0:36</p> <p style="text-align: center;">STATE OF HAWAII<br/>DEPARTMENT OF HEALTH<br/>STATE LICENSING</p> |

Licensee's/Administrator's Signature: \_\_\_\_\_ 

Print Name: JESUSA RAMOS (SUSAN RAMOS CARE HOME, LLC)

Date: 5/18/23

Licensee's/Administrator's Signature: \_\_\_\_\_ 

Print Name: JESUSA RAMOS (SUSAN RAMOS CARE HOME, LLC)

Date: 9/18/23

23 MAY 16 AM 25  
STILLINGBORG