Office of Health Care Assurance

**State Licensing Section**

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| Facility's Name: Bolosan, Domie (ARCH) | CHAPTER 100.1 |
|---|---|
| Address:<br>94-039 Waikele Loop, Waipahu, Hawaii 96797 | Inspection Date: June 4, 2024 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 PER HAR 11-100.1-3(e)(2). IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

**FAILURE TO CORRECT CITED DEFICIENCIES AS PER THE PLAN OF CORRECTION COULD RESULT IN REFUSAL TO RENEW YOUR LICENSE PER HAR 11-100.1-3(e)(3).**

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-3 Licensing. (b)(1)(I)<br>Application.<br><br>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:<br><br>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;<br><br>**FINDINGS**<br>Substitute Care Giver (SCG) #3 – No Fieldprint background check available. | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>No action/corrections made to this deficiency, as Substitute Caregiver #3, will no longer be a substitute caregiver for my care home effective immediately. DOH RN - J.C. notified via email on August 1, 2024. | 08/01/2024 |

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|---|---|---|---|
| ☒ | §11-100.1-9 <u>Personnel, staffing and family requirements.</u><br>(b)<br>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.<br><br>**<u>FINDINGS</u>**<br>SCG #3 – No annual tuberculosis clearance as there was no signature by a physician or APRN. | **PART 1**<br><br>**<u>DID YOU CORRECT THE DEFICIENCY?</u>**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>No action/corrections made to this deficiency, as Substitute Caregiver #3, will no longer be a substitute caregiver for my care home effective immediately. DOH RN - J.C. notified via email on August 1, 2024. | 08/01/2024 |

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|---|---|---|---|
| ☒ | §11-100.1-15 Medications. (e)<br>All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.<br><br>**FINDINGS**<br>Resident #1 – Medication order from 4/3/2024 = Fluticasone Propionate suspension 50 mcg/act – 1 spray in each nostril, once a day. Medication not administered once a day as ordered. Medication administration record says "hold," and hasn't been administered once. | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>Resident #1 refused to take the Fluticasone spray, as she stated she no longer has a stuffy or runny nose.<br>Took Resident #1 to the doctor on June 13, 2024, doctor discontinued medication. | 06/13/2024 |

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Licensee's/Administrator's Signature: Domie B. Bolosan

Print Name: Domie B. Bolosan

Date: Jun 17, 2024

Licensee's/Administrator's Signature: Domie Bolosan

Print Name: Domie Bolosan

Date: Aug 5, 2024