

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name: Victoria Expanded Care Home LLC</b>	<b>CHAPTER 100.1</b>
<b>Address: 94-1381 Hiaai Place, Waipahu, Hawaii 96797</b>	<b>Inspection Date: April 12, 2024 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 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
<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></p> <ul style="list-style-type: none"> <li>• Substitute Care Giver (SCG) #3 – No Fieldprint background check.</li> <li>• Household Member (HM) #1 – Fieldprint background check = red light determination.</li> </ul>	<p><b>PART 1</b></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>Yes, I corrected the deficiency of the Substitute Care Giver (SCG) #3. He has already obtained his Fieldprint background check dated April 23, 2024 and the result was green light determination. It was already filed in my Care home binder. As to Household Member (HM) #1, who was found out to have red light determination, I already sent my appeal to the Department of Health and I am still waiting for the result.</p>	<p>04/23/2024</p>

	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<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></p> <ul style="list-style-type: none"> <li>• Substitute Care Giver (SCG) #3 – No Fieldprint background check.</li> <li>• Household Member (HM) #1 – Fieldprint background check = red light determination.</li> </ul>	<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>The PCG has created a checklist with all caregiver requirements which includes Fieldprint background checks. This checklist will be reviewed by the PCG quarterly and a reminder will be placed on the front of my carehome binder, as well as written on my calendar so I do not forget to check.</p>	07/22/2024

	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><b><u>FINDINGS</u></b></p> <ul style="list-style-type: none"> <li>• SCG #1 – No annual tuberculosis clearance.</li> <li>• SCG #1 and #2 – No initial/2-step tuberculosis clearance.</li> </ul>	<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>SCG # 1 Done her skin test on 07/20/2024. While SCG # 2 done her skin test on 07/26/2024.</p>	<p>07/22/2024</p>

	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<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><b><u>FINDINGS</u></b></p> <ul style="list-style-type: none"> <li>• SCG #1 – No annual tuberculosis clearance.</li> <li>• SCG #1 and #2 – No initial/2-step tuberculosis clearance.</li> </ul>	<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>The PCG has created a checklist with all caregiver requirements which includes TB Clearance results. To ensure TB clearances are obtained and available, the documents of the aforementioned clearance will be included in the carehome binder. I will be the one who is responsible to check that the TB clearances are available quarterly and check the TB clearances prior to the 1 year period of their skin test. A reminder will be written on my calendar, so I do not forget to check.</p>	07/22/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p><b><u>FINDINGS</u></b> Resident #1 – Monthly progress notes do not include observations of the resident's response to diet or medications.</p>	<p><b>PART 1</b></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>Yes, from now on and days forward, I will include my observations toward resident's response to medication, treatments, diet, case plan, changes in condition if any, indications of illness or injury, behavioral patterns reflected in the Monthly progress notes and other relevant matters as required.</p>	<p>04/25/2024</p>

	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p><b><u>FEEDINGS</u></b> Resident #1 – Monthly progress notes do not include observations of the resident's response to diet or medications.</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 will give all my substitute caregivers an in- service designated duties. My SCG#1 will be the one to check the progress notes after I filled out the monthly progress notes by the end of the month. Moreover, another SCG #2 will double check everything that has been documented completely monthly. Lastly, my SCG #3 will also check the monthly progress notes quarterly.</p>	07/22/2024

Licensee's/Administrator's Signature: Vicky C. Bagain

Print Name: Vicky Cadiz Bagain

Date: Apr 25, 2024



Licensee's/Administrator's Signature: Vicky C. Bagain

Print Name: Vicky Cadiz Bagain

Date: Jul 25, 2024