

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Elisa Cabal	CHAPTER 100.1
Address: 228 Hookano Street, Hilo, Hawaii 96720	Inspection Date: October 7, 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
<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> Substitute Care Giver (SCG) #3 – No documented evidence that the care giver has no prior felony or abuse convictions in a court of law, on file.</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 style="text-align: center;"><i>the care giver for gave me the for finger print and I put it in my file</i></p>	<p style="text-align: right;"><i>11/4/24</i></p> <p style="text-align: right;">24 NOV -6 110:44</p> <p style="text-align: right;">STATE LICENSING</p>

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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>FINDINGS Substitute Care Giver (SCG) #3 – No documented evidence that the care giver has no prior felony or abuse convictions in a court of law, on file.</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 style="font-size: 1.2em; color: blue;"><i>me + my substitute will check the site my folder to check if updated every 2 months.</i></p>	<p style="text-align: right; font-size: 1.5em; color: blue;"><i>11/2/24</i></p> <p style="text-align: right; font-size: 0.8em;">24 NOV -6 10:44 STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Observed “Dorzolamide 2% solution, 1 drop in both eyes twice a day as directed” in resident’s medication bin. No documented evidence of a physician or advanced practice registered nurse (APRN) medication order for aforementioned medication.</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 style="text-align: right;">10/7/24</p> <p>after my inspection I destroy my residents eye drop in my medicine Pam got I drop the order to the doctors office & put it in the file</p>	<p style="text-align: right;">11/4/2024 #</p> <p style="text-align: right;">24 NOV -6 10:44</p> <p style="text-align: right;">STATE OF MICHIGAN STATE LICENSING</p>

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Licensee's/Administrator's Signature: EUSA CABAL

Print Name: EUSA CABAL

Date: 11/4/24

STATE OF NEW YORK
DEPARTMENT OF
STATE LICENSING

24 NOV -6 10:44