Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Imiloa Care Home LLC	**CHAPTER 100.1**
Address: **94-860 Lumiiki Street, Waipahu, Hawaii 96797**	**Inspection Date: March 18. 2025 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) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(7) During residence, records shall include: Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency; **FINDINGS** Resident #1: No documented evidence of monthly height and weight.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Resident #1 Case Manager was contacted and made aware of citation. It was confirmed that monthly are circumference measurements were being documented by the case manager in place of weight due to the resident's inability to safely stand on a scale in cm notes. - The case manager was in process of requesting from Primary Doctor a formal order supporting the use of monthly mid-upper arm circumference in lieu of monthly weights, since order was not obtained yet cm as documenting in personal notes in regard to resident. - Obtained a physician order and case manager letter and emailed a copy. - Case Manager has since trained PCG on how to take and record document arm circumference.	3/18/25

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-84 Admission requirements. (b)(3) Upon admission of a resident, the expanded ARCH licensee shall have the following information: Evidence of compliance with the department's uniform tuberculosis policy; **FINDINGS** Resident #2: No documented evidence of pre-admission tuberculosis clearance, per department's tuberculosis policy.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - Resident passed before being able to obtain documentation of TB clearance.	3/25/25

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☒	§11-100.1-84 Admission requirements. (b)(3) Upon admission of a resident, the expanded ARCH licensee shall have the following information: Evidence of compliance with the department's uniform tuberculosis policy; **FINDINGS** Resident #2: No documented evidence of pre-admission tuberculosis clearance, per department's tuberculosis policy.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** - A Pre-Admission Documentation Checklist has been implemented and must be completed before any resident is officially admitted. TB clearance is now a required field on checklist. - PCG will conduct a monthly audit of all new admission records to confirm that TB clearance documentation is present and dated prior to admission. - 2 step TB clearance will be verified at the time of admission by the PCG using checklist. - Then added TB test to my phone calendar for reminder Annually TB test and also to my yearly calendar posted to easily visible who needed TB test annually using resident initial for privacy.	3/25/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-86 Fire safety. (a)(4) A Type I expanded ARCH shall be in compliance with existing fire safety standards for a Type I ARCH, as provided in section 11-100.1-23(b), and the following: Hard wired smoke detectors shall be approved by a nationally recognized testing laboratory and all shall be tested at least monthly to assure working order; **FINDINGS** No documented evidence that smoke detectors were tested for the month of February 2025.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** - Smoke Detector were immediately tested upon identification of the citation to ensure functionality. - A backdated log entry was not made; instead, a note was added to February's file documenting that the test had not been recorded, and corrective action is in place to prevent recurrence. - All subsequent monthly tests have been completed and documented appropriately.	3/18/25

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☒	§11-100.1-86 Fire safety. (a)(4) A Type I expanded ARCH shall be in compliance with existing fire safety standards for a Type I ARCH, as provided in section 11-100.1-23(b), and the following: Hard wired smoke detectors shall be approved by a nationally recognized testing laboratory and all shall be tested at least monthly to assure working order; **FINDINGS** No documented evidence that smoke detectors were tested for the month of February 2025.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** - PCG will verify smoke detector testing and documentation monthly initial the log for quality assurance - Documentation will be reviewed quarterly by the PCG to ensure compliance is maintained and to reinforce accountability - Telephone Calendar will be used to remind PCG to do monthly checks.	3/18/25

Licensee's/Administrator's Signature: _____

Print Name: MYLENE MABALLO

Date: 6/17/2025