STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Imelda G. Arreola (ARCH/Expanded ARCH)	**CHAPTER 100.1**
Address: **87-164 Kaukamana Street, Waianae, Hawaii 96792**	**Inspection Date: April 23, 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 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
☒	§11-100.1-20 Resident health care standards. (e) Arrangements shall be made by the primary care giver for annual dental examinations. Arrangements shall be made by the primary or substitute care giver for emergency dental examinations. **FINDINGS** Resident #1- No documented evidence of an annual dental examination. Resident has been admitted since 10/15/22.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** Yes **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I, the RCG text the family to verify if the resident has a dental insurance coverage and will make appointment to the dentist.	4/24/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-20 Resident health care standards. (e) Arrangements shall be made by the primary care giver for annual dental examinations. Arrangements shall be made by the primary or substitute care giver for emergency dental examinations. **FINDINGS** Resident #1- No documented evidence of an annual dental examination. Resident has been admitted since 10/15/22. —	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future to prevent this deficiency to happen again I, the PCC will create a checklist to list the annual dental examination. This checklist will be in place in the resident binder and refer to this checklist when I do my monthly audit.	4/24/25

Licensee's/Administrator's Signature: Imelda Arcola

Print Name: Imelda Arcola

Date: 5-5-2025