Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: AJ Adult Residential Care Home	**CHAPTER 100.1**
Address: **2529 Rose Street, Honolulu, Hawaii, 96819**	**Inspection Date: October 24, 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).

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. **FINDINGS** Resident #1— Physician order: "Calcium 600mg tablet, take 1 tab orally daily at breakfast." Unlabeled "Calcium 60mmg tablet with Vitamin D3(400IU)" medication bottle observed in resident's medication bin.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The unlabeled medication was removed from the medication bin immediately to prevent administration error.	11/05/25

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☒	§11-100.1-15 Medications. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. **FINDINGS** Resident #1—Physician order: "Calcium 600mg tablet, take 1 tab orally daily at breakfast." Unlabeled "Calcium 60mmg tablet with Vitamin D3(400IU)" medication bottle observed in resident's medication bin.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Preventive Measure: PCG (Primary Care Giver) will re-educate staff on the importance of ensuring all medications are properly labeled at all times. PCG (Primary Care Giver) will make sure that upon receipt of any OTC (over the counter) medication, caregiver will, verify the medication matches the physician's order (name, dosage, route, frequency). Clearly label the medication container with resident's full name, medication name, strength, directions for use, and date received for proper labeling.	11/05/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1—Physician order: "Calcium 600mg tablet, take 1 tab orally daily at breakfast." Bottle observed in medication bin labeled "Calcium 600mg tablet with Vitamin D3(400IU)." Medication available to resident does not match physician order.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Bought new OTC medication to match with the physician's order.	11/05./25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1—Physician order: "Calcium 600mg tablet, take 1 tab orally daily at breakfast." Bottle observed in medication bin labeled "Calcium 600mg tablet with Vitamin D3(400IU)." Medication available to resident does not match physician order.	**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 PCG will make sure to bring physicians order to the pharmacy when buying over the counter medication to match the medication and the physician's order and PCG will also provide family a copy of the physicians order to make sure they buy the correct medication. Also reminded SCG to handed the medication to PCG first to double check if the medication matches the physicians order before adding it to their medication box. I also posted a reminder infront of my medication cabinet about matching physicians order with the over the counter medication before adding it to their medicine box.	12/10/25

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. **FINDINGS** Resident #1—Physician order: "Calcium 600mg tablet, take 1 tab orally daily at breakfast." Bottle observed in medication bin labeled "Calcium 600mg tablet with Vitamin D3(400IU)." Medication administered to resident does not match physician order.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications. **FINDINGS** Observed "Simbrinza" eye drops on kitchen counter, unsecured.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Simbrinza bottle was immediately removed from the counter and restored in a locked medication cabinet. The area was checked to confirm no other unsecured medications were present. PCG verbally reminded substitute of medication storage procedures.	11/05/25

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications. **FINDINGS** Bedroom #4—One (1) blue tablet and one (1) white tablet observed unsecured in a medication cup on the resident's bedside table.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The unsecured medications (1 blue pill and 1 white pill) were immediately removed from the bedside table and secured in the resident's locked medication storage. Staff were reminded of proper medication storage procedures per facility policy to prevent unsecured medications at the bedside. Documentation of the incident was completed in the resident's record.	11/05/25

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-83 Personnel and staffing requirements. (5) In addition to the requirements in subchapter 2 and 3: Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents. **FINDINGS** Primary Care Giver (PCG), Substitute Care Giver (SCG) #1, SCG #2, and SCG #3—No documented evidence of twelve (12) continuing education hours completed within the past twelve (12) months.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Attended a class and obtain a certificate for the missing hours of co ntinuing education dated October 30,2025 and November 3,2025 for both PCG and SCG.	12/1025

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Licensee's/Administrator's Signature: _____

Print Name: Christine Bragado

Date: Nov 5, 2025

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Licensee's/Administrator's Signature: _____

Print Name: Christine Bragado

Date: Dec 10, 2025

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