

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name: RJ Santiago ARCH &amp; E-ARCH</b>	<b>CHAPTER 100.1</b>
<b>Address: 94-571 Loaa Street, Waipahu, Hawaii 96797</b>	<b>Inspection Date: July 8, 2025 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>§11-100.1-7 <u>General operational policies.</u> (c)  A written agreement shall be completed at the time of admission between the licensee or primary care giver of the ARCH or expanded ARCH and the ARCH or expanded ARCH resident and the ARCH or expanded ARCH resident's family, legal guardian, surrogate or responsible agency that sets forth that resident's rights, the licensee or primary care giver of the ARCH or expanded ARCH responsibilities to that resident, the services which will be provided by the licensee or primary care giver of the ARCH or expanded ARCH according to that resident's schedule of activities or care plan, and that resident's responsibilities to the licensee or primary care giver of the ARCH or expanded ARCH.</p> <p><b><u>FINDINGS</u></b>  Resident #1 – Care home policy was not signed/dated by the resident/family at readmission on 2/26/2024.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u> YES</b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>The policy was signed on 7/9/2025.</p>	<p style="text-align: center;">7/9/25</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-7 <u>General operational policies.</u> (c)  A written agreement shall be completed at the time of admission between the licensee or primary care giver of the ARCH or expanded ARCH and the ARCH or expanded ARCH resident and the ARCH or expanded ARCH resident's family, legal guardian, surrogate or responsible agency that sets forth that resident's rights, the licensee or primary care giver of the ARCH or expanded ARCH responsibilities to that resident, the services which will be provided by the licensee or primary care giver of the ARCH or expanded ARCH according to that resident's schedule of activities or care plan, and that resident's responsibilities to the licensee or primary care giver of the ARCH or expanded ARCH.</p> <p><b><u>FINDINGS</u></b>  Resident #1 – Care home policy was not signed/dated by the resident/family at readmission on 2/26/2024.</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>To prevent this deficiency from happening again in the future, I have to add in my readmission checklist that resident must sign the Care Home Policy upon readmission from hospital or other facility.</p>	<p style="text-align: center;">7/28/25</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (b)            Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.</p> <p><b>FINDINGS</b>            Unlabeled Medicaid Chest Rub was left unsecured in residents' bedroom #3. Corrected during the inspection.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p style="text-align: center;">7/8/25</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (h)  All telephone and verbal orders for medication shall be recorded immediately on the physician's order sheet and written confirmation shall be obtained at the next physicians visit and not later than four months from the date of the verbal order for the medication.</p> <p><b>FINDINGS</b>  Resident #1 – Per medication administration record (MAR), Rifampin 300mg, 2 capsules daily was discontinued on 5/30/2025. There was no physician's order. Primary care giver (PCG) stated that a verbal order to stop after four (4) months was given during the 5/15/2025 office visit, but not recorded. PCG recorded in physician's order sheet during the inspection.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p style="text-align: center;">7/8/25</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (f)(4)            General rules regarding records:</p> <p>All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency.</p> <p><b><u>FINDINGS</u></b>            Resident #1 – Case manager visited on 6/13/2025. No record was provided to the care home as of 7/8/2025 on the day of the inspection.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b> <i>YES</i></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>I did obtain the record from RN case manager on 7/13/25.</i></p>	<p style="text-align: center;"><i>8/26/25</i></p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-19 <u>Resident accounts.</u> (a)            The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative.</p> <p><b><u>FINDINGS</u></b>            Resident #1 – Financial statement was not signed/dated by the resident/family at readmission on 2/26/2024.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u> YES</b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;">Financial statement was signed on 7/9/25.</p>	<p>7/9/25</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-19 <u>Resident accounts.</u> (a)  The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative.</p> <p><b>FINDINGS</b>  Resident #1 – Financial statement was not signed/dated by the resident/family at readmission on 2/26/2024.</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>To prevent this deficiency from happening again in the future. I have added in my checklist that resident must sign a new financial statement upon readmission from hospital or other facility.</i></p>	<p><i>7/28/25</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(2)            Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident;</p> <p><b>FINDINGS</b>            Resident #1 – Diagnoses included essential hypertension, not addressed in care plan.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u> YES</b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>As of Individual Service Plan (ISP) that was done on 7/10/25, diagnosis of essential HTN was discussed among circle of support and care developed to include hypertension added on the care plan. It should be stated in the Individual Plan goals &amp; outcome.</i></p>	<p style="text-align: center;"><i>7/10/25</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(9)            Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Provide ongoing evaluation and monitoring of the expanded ARCH resident's status, care giver's skills, competency and quality of services being provided:</p> <p><b>FINDINGS</b>            Resident #1 – No record that a case manager took blood pressure at monthly visits. Blood pressure for comprehensive assessment on 3/21/2025 was left blank. For June 2024 and July 2024, blood pressures were recorded as “refused.” From Aug 2024 to May 2025, blood pressures were recorded as “UTA,” reasons were not recorded.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	<p style="text-align: center;">7/8/25</p> <p style="text-align: right;">25 JUL 2025</p>

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Licensee's/Administrator's Signature: Juliet Santiago

Print Name: JULIET SANTIAGO

Date: 7/28/2025

Licensee's/Administrator's Signature: Juliet Santiago

Print Name: JULIET SANTIAGO

Date: 8/26/2025