

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Castanaga, Imelda (ARCH/Expanded ARCH)	CHAPTER 100.1
Address: 94-972 Lumimoe Street, Waipahu, Hawaii 96797	Inspection Date: August 11, 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
<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 -- No supply available to administer PRN Acetaminophen (Tylenol) 500 mg tablet.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u> YES</p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>Tylenol 500 mg. Tablet was purchased and put in a medicine tray.</i></p>	<i>8/12/25</i>

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<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 -- No supply available to administer PRN Acetaminophen (Tylenol) 500 mg tablet.</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><i>I will check my supply 8/12/25 on a weekly basis to make sure supply is available when needed.</i></p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><u>FINDINGS</u> Resident #1 - No documentation of annual tuberculosis (TB) clearance. <i>Submit a copy with your plan of correction.</i></p>	<p style="text-align: center;">PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u> <i>Yes</i></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Enclosed a copy of Tuberculosis Clearance form.</i></p>	<p><i>9/12/25</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><u>FINDINGS</u> Resident #1 - No documentation of annual tuberculosis (TB) clearance.</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><i>I will keep a copy of TB clearance form on hand in case the provider misplace the form.</i></p>	<p><i>9/10/25</i></p>

Licensee's/Administrator's Signature: Imelda B. Castanaga

Print Name: IMELDA B. CASTANAGA

Date: 11/22/25