

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Editha Rogelio Tapat ARCH, LLC	CHAPTER 100.1
Address: 94-432 Kipou Street, Waipahu, Hawaii 96797	Inspection Date: March 10, 2026 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>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(8) 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>Have face-to-face contacts with the expanded ARCH resident at least once every thirty days, with more frequent contacts based on the resident's needs and the care giver's capabilities;</p> <p><u>FINDINGS</u> Resident #1— Records to verify 30-day face-to-face contact with the case manager are unavailable for review.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</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)(8) 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>Have face-to-face contacts with the expanded ARCH resident at least once every thirty days, with more frequent contacts based on the resident's needs and the care giver's capabilities;</p> <p><u>FINDINGS</u> Resident #1— Records to verify 30-day face-to-face contact with the case manager are unavailable for review.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p>	

Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____