

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Pleasant Valley Type I EARCH	CHAPTER 100.1
Address: 1573 Kilohana Street, Honolulu, Hawaii 96813	Inspection Date: April 1, 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>§11-100.1-3 <u>Licensing</u>, (b)(1)(I) Application.</p> <p>In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application:</p> <p>Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law;</p> <p><u>FINDINGS</u> Available background results did not meet DOH requirements.</p> <p>-PCG: 9/25/25 and 4/18/23 (APS, CAN, Fingerprint) -SCG #1: 5/12/25 (eCrim only), 5/3/23 (APS, CAN, Fingerprint) -SCG #2: 6/9/22 (APS, CAN, Fingerprint), 2/12/24 (APS, CAN), 5/12/25 (eCrim only) -SCG #3: 6/22/22 (APS, CAN, Fingerprint), 2/12/24 (APS, CAN), 5/12/25 (eCrim only) -HM #1: 2/24/26 and 4/18/23 (APS, CAN, Fingerprint), 5/12/25 (eCrim only)</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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	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 – Orders 12/12/25 and 11/3/25 included “DULCOLAX SUPPOSITORY 10MG (BISACODYL) – Insert 1 suppository rectally every 24 hrs PRN for no BM x3days or if Lactulose ineffective.” There was no order for lactulose. Lactulose was not available at home.</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>	

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____