Office of Health Care Assurance

**State Licensing Section**

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| Facility's Name: Cachola Adult Residential Care Home | CHAPTER 100.1 |
|---|---|
| Address:<br>98-314 Ponokaulike Street, Aiea, Hawaii 96701 | Inspection Date: February 5, 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 |
|---|---|---|---|
| ☒ | §11-100.1-9 Personnel, staffing and family requirements.<br>(a)<br>All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.<br><br>FINDINGS<br>Household Member (HHM) #1 -- No documented evidence of a current physical examination clearance by a physician or advanced practice registered nurse (APRN) on file. | PART 1<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br><br>Yes, results has been placed in carehome binder. | 3/17/2026<br><br>'26 APR 29 AM 1:37 |

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-9 Personnel, staffing and family requirements.<br>(a)<br>All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.<br><br>**FINDINGS**<br>HHM #1 – No documented evidence of a current physical examination clearance by a physician or APRN on file. | **PART 2**<br><br>**FUTURE PLAN**<br><br>**USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**<br><br>I will maintain a checklist of requirements that is needed to be updated yearly for my household members, SCG and PCG and place it on my carehome binder. | 3/17/26 |

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|  | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-9 Personnel, staffing and family requirements.<br>(b)<br>All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.<br><br>**FINDINGS**<br>HHM #1 – No documented evidence of a current tuberculosis clearance by a physician or APRN on file. | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**<br>yes, results has been placed in carehome binder. | 3/17/26.<br><br>'26 APR 29 AM :37 |

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
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| ☒ | §11-100.1-9 <u>Personnel, staffing and family requirements.</u><br>(b)<br>All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.<br><br>**<u>FINDINGS</u>**<br>HHM #1 – No documented evidence of a current tuberculosis clearance by a physician or APRN on file. | **PART 2**<br><br>**<u>FUTURE PLAN</u>**<br><br>**USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**<br>I will maintain a checklist of requirements that is needed to be updated yearly for my household members, SCG and PCG and place it on my carehome binder. | 3/17/26 |

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Licensee's/Administrator's Signature: [signature]

Print Name: Madelaine Cachola

Date: 4/20/2026

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