

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Devoted Home, LLC	CHAPTER 100.1
Address: 94-572 Apii Place, Waipahu, Hawaii 96797	Inspection Date: March 4, 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"/> §11-100.1-15 Medications: (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. FINDINGS Resident #1 – Physician ordered Acetaminophen 500mg tablet, take 2 tablets by mouth every 6 hours as needed” and “Bisacodyl 10mg suppository, insert 1 supp rectally daily as needed.” Medication labels for aforementioned medications without as needed (PRN) indication.	<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> <p>ON 4/1/2026 PCG CALLED RESIDENT'S PCP TO MAKE CHANGES/CORRECTIONS TO ACETAMINOPHEN TABLETS & BISACODYL 10MG SUPPOSITORY ORDER. PCP WAS ABLE TO MAKE CORRECTIONS & ADDED PRN INDICATIONS AND DIAGNOSIS TO BOTH MEDICATIONS SENT IT TO THE PHARMACY. RECEIVED CORRECTED MEDICATION LABEL FROM PHARMACY.</p>	<p style="text-align: right;">4/1/2026</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-15 Medications. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. FINDINGS Resident #1 - Physician ordered Acetaminophen 500mg tablet, take 2 tablets by mouth every 6 hours as needed" and "Bisacodyl 10mg suppository, insert 1 supp rectally daily as needed." Medication labels for aforementioned medications without a PRN indication.	<p style="text-align: center;">PLAN OF CORRECTION</p> <p style="text-align: center;">PART 2</p> <p style="text-align: center;"><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> <p>TO ENSURE THAT IT DOESN'T HAPPEN AGAIN PCC WILL VERIFY/CONFIRM WITH THE PHYSICIAN GIVING THE ORDER TO INCLUDE PRN INDICATIONS/DIAGNOSIS ON THE MEDICATION ORDERS BEFORE LEAVING THE DOCTOR'S OFFICE SO AS TO CONFIRM WITH THE PHARMACY PRIOR TO RECEIVING THE MEDICATION. PCC/SCG WILL BOTH ASK THE MEDICATION IS PROPERLY LABELED WITH PRN INDICATIONS/DIAGNOSIS ON A MONTHLY BASIS.</p>	<p style="text-align: center;">4/1/2026</p> <p style="text-align: center;">26 MAY 15 PM 2:02</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. FINDINGS Resident #1 – Physician ordered Acetaminophen 500mg tablet, take 2 tablets by mouth every 6 hours as needed” and “Bisacodyl 10mg suppository, insert 1 supp rectally daily as needed.” Physician order does not include PRN indication.	<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> <p> CALLED PCP OFFICE TO MAKE CORRECTIONS ON RESIDENT'S MEDICATIONS ACETAMINOPHEN 500MG ^{and} BISACODYL 10MG SUPPOSITORY PRN TO ADD PRN INDICATIONS/DIAGNOSIS. CORRECTIONS WERE MADE ON 4/1/2026. </p>	<p style="text-align: center;">4/1/2026</p>

STATE OF MARYLAND
 DEPARTMENT OF HEALTH
 DIVISION OF LICENSING
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RULES (CRITERIA)	PLAN OF CORRECTION PART 1	Completion Date
<input checked="" type="checkbox"/> §11-100.1-88 Case management qualifications and services. (c)(3) 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: Review the care plan monthly, or sooner as appropriate; FINDINGS Resident #1 – No documented evidence that the registered nurse (RN) case manager reviews the resident's care plan monthly, or sooner as appropriate, on file for department review.	<p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>ON 5/4/2026, CASE MANAGER RN CAME TO ASSESS & REVIEWED RESIDENT #1 CARE PLAN. NOTES DONE & FILED IN RESIDENT'S BANDER.</p>	<p style="text-align: center;">5/4/2026</p>

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-88 Case management qualifications and services. (c)(3) 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: Review the care plan monthly, or sooner as appropriate; FINDINGS Resident #1 – No documented evidence that the RN case manager reviews the resident's care plan monthly, or sooner as appropriate, on file for department review.	<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 style="text-align: center;">TO ENSURE THAT IT DOESN'T HAPPEN AGAIN I WILL HAVE 2 CAREGIVERS DOUBLE CHECK THAT IT IS DONE & FILED IN RESIDENT'S BINDER ON A MONTHLY BASIS.</p>	<p style="text-align: center;">5/4/2026</p> <p style="text-align: center;">26 MAY 15 12:02</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-88 Case management qualifications and services. (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: 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; FINDINGS Resident #1 – No documented evidence that the RN case manager have face-to-face contact with the resident at least once every thirty days, with more frequent contacts based on the resident's needs and the care giver's capabilities.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	26 MAY 15 PM 02 STATE OF MICHIGAN STATE LICENSURE

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-88 Case management qualifications and services. (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: 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; FINDINGS Resident #1 - No documented evidence that the RN case manager have face-to-face contact with the resident at least once every thirty days, with more frequent contacts based on the resident's needs and the care giver's capabilities.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><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> <p>TO ENSURE THAT IT DOESN'T HAPPEN AGAIN I WILL HAVE 2 CAREGIVERS TO DOUBLE CHECK THAT AN RN CASE MANAGER'S FACE-TO-FACE CONTACT W/ THE RESIDENT IS SCHEDULED & DONE ON A MONTHLY BASIS.</p>	<p style="text-align: right;">5/4/2022</p> <p style="text-align: right;">26 MAY 15 PM 02</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-88 Case management qualifications and services. (c)(10) 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: Conduct comprehensive reassessments of the expanded ARCH resident every six months or sooner as appropriate; FINDINGS Resident #1 – No documented evidence that the RN case manager conducts comprehensive reassessments of the expanded adult residential care home (ARCH) resident every six (6) months or sooner as appropriate, on file.	<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> <p style="text-align: center;"> CASE MANAGEMENT RN CAME TO VISIT AND ASSESSED RESIDENT #1 ON 5/4/2026. ASSESSMENT NOTES WERE DONE & FILED IN RESIDENT'S BINDER. </p>	<p style="text-align: center;">5/4/2026</p> <p style="text-align: center;">26 MAY 15 P12:02</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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Licensee's/Administrator's Signature:



Print Name: MARI-SEANNE MENDOZA

Date: MAY 15 2026

STATE OF ILLINOIS
STATE LICENSING

26 MAY 15 PM 2:02