

26 MAY -6 P2:00
STATE LICENSING SECTION
OFFICE OF HEALTH CARE ASSURANCE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Garcia Care Home	CHAPTER 100.1
Address: 99-568 Huakanu Street, Aiea, Hawaii 96701	Inspection Date: February 20, 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"/> §11-100.1-3 Licensing. (b)(1)(I) Application. 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: 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; FINDINGS Substitute Caregiver (SCG) #2—No documentation of a recent background check confirming caregiver has no prior felony or abuse convictions in a court of law. Last background check on file is dated 3/16/2022. <i>Please provide documentation with your plan of corrections (POC).</i>	<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;"><i>checked. copy enclosed.</i></p>	<p style="text-align: center;"><i>3-31-2026</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-3 <u>Licensing: (b)(1)(I)</u> Application. 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: 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; <u>FINDINGS</u> Substitute Caregiver (SCG) #2—No documentation of a recent background check confirming caregiver has no prior felony or abuse convictions in a court of law. Last background check on file is dated 3/16/2022.	<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;"><i>will write a note in the calendar 3-31-2026 to remind before the expiration.</i></p>	<p style="text-align: center;">26 MAY -6 P2:03</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-3 Licensing. (b)(1)(I) Application. 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: 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; FINDINGS Substitute Caregiver (SCG) #4—No documentation of a recent background check confirming caregiver has no prior felony or abuse convictions in a court of law. Last background check on file is dated 05/16/2024. <i>Please provide documentation with your plan of corrections (POC).</i>	<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;"><i>CO checked. copy enclosed.</i></p>	<p style="text-align: center;"><i>3-26-2026</i></p> <p style="text-align: center;">26 MAY -6 P 2:03</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-3 <u>Licensing</u> . (b)(1)(I) Application. 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: 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; <u>FINDINGS</u> Substitute Caregiver (SCG) #4—No documentation of a recent background check confirming caregiver has no prior felony or abuse convictions in a court of law. Last background check on file is dated 05/16/2024.	<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;"><i>will write a note in the calendar 3-26-2026 to remind before the expiration.</i></p>	<p style="text-align: center;">26 MAY -6 P2:04</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 Records and reports. (f)(4) General rules regarding records: All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency. FINDINGS Resident #1—Level of Care (LOC) assessment information inaccurate. Scores do not match level of care indicated. <i>Please provide documentation with your plan of corrections (POC).</i>	<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;"><i>Corrected. Copy enclosed</i></p>	<p style="text-align: center;"><i>2-27-2026</i></p>

STATE LICENSING
MAY -6 P2:04

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 Records and reports. (f)(4) General rules regarding records: All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency. FINDINGS Resident #1—Level of Care (LOC) assessment information inaccurate. Scores do not match level of care indicated.	<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;"><i>Make sure to double check the scores are accurate.</i></p>	<p style="text-align: center;"><i>2-27-2024</i></p>

STATE OF MICHIGAN
 STATE LICENSING
 26 MAY -6 P2:04

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (a) 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. FINDINGS Substitute Caregiver (SCG) #1—No current annual physical exam available for review. Last available record dated 02/09/2024. <i>Please provide documentation with your plan of corrections (POC).</i>	<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;"><i>corrected. Copy enclosed.</i></p>	<p style="text-align: center;"><i>3-23-2024</i></p>

STATE OF MICHIGAN
 DEPARTMENT OF CORRECTIONS
 26 MAY -6 P 2:04

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) 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. FINDINGS Substitute Caregiver (SCG) #1—No current annual physical exam available for review. Last available record dated 02/09/2024.	<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;"><i>will write a note in the calendar to remind before the expiration.</i></p>	<p style="text-align: center;">3-23-2024</p>

STATE OF CONNECTICUT
 DEPARTMENT OF SOCIAL SERVICES
 26 MAY -6 P 2:02

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) 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. FINDINGS Substitute Caregiver (SCG) #1—No current annual tuberculosis clearance available for review. SCG #2—No current annual tuberculosis clearance available for review. <i>Please provide documentation with your plan of corrections (POC).</i>	<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;"><i>corrected. copy enclosed.</i></p>	<p style="text-align: center;"><i>3-26-2026</i></p>

STATE OF MICHIGAN
 DEPT. OF HEALTH
 26 MAY -6 P 2:04

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) 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. <u>FINDINGS</u> Substitute Caregiver (SCG) #1—No current annual tuberculosis clearance available for review. SCG #2—No current annual tuberculosis clearance available for 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;"><i>will write a note in the calendar - 3-26-2026 date to remind before the expiration.</i></p>	<p style="text-align: center;">26 MAY -6 P 2:04</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. FINDINGS Substitute Caregiver (SCG) #2—No documentation of training done by the primary caregiver (PCG) to make medications available to residents. <i>Please provide documentation with your plan of corrections (POC).</i>	<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;"><i>Corrected. Copy enclosed</i></p>	<p style="text-align: center;"><i>9-10-2026</i></p>

STATE OF MONTANA
 HEALTH CARE
 STATE LICENSING

26 MAY -6 P 2:04

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. FINDINGS Substitute Caregiver (SCG) #2—No documentation of training done by the primary caregiver (PCG) to make medications available to residents.	<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;"><i>Will write a note in the calendar to remind before the expiration.</i></p>	<p style="text-align: center;"><i>3-10-2026</i></p> <p style="text-align: center;">26 MAY -6 P2:05</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; FINDINGS Substitute Caregiver (SCG) #2— No record that SCG is certified in first aid. <i>Please provide documentation with your plan of corrections (POC).</i>	<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;"><i>Corrected. Copy enclosed.</i></p>	<p style="text-align: center;"><i>3-21-2026</i></p>

MAY -6 26 12:05 PM '26

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> § 11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; FINDINGS Substitute Caregiver (SCG) #2— No record that SCG is certified in first aid.	<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;"><i>will write a note in the color - 3-21-2026 don't remind before the operation.</i></p>	<p style="text-align: center;">26 MAY -6 PM 05</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> § 11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall: Be currently certified in cardiopulmonary resuscitation; FINDINGS Substitute Caregiver (SCG) #2—No record that SCG is certified in cardiopulmonary resuscitation. <i>Please provide documentation with your plan of corrections (POC).</i>	<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;"><i>Checked. Copy enclosed</i></p>	<p style="text-align: center;"><i>3-21-2024</i></p>

MAY -6 P2:05

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> § 11-100.1-9 Personnel, staffing and family requirements. (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall: Be currently certified in cardiopulmonary resuscitation; FINDINGS Substitute Caregiver (SCG) #2—No record that SCG is certified in cardiopulmonary resuscitation.	<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><i>will write a note in the calendar to remind before the expiration.</i></p>	<p style="text-align: center;"><i>3-21-2024</i></p>

MAY -6 P2:05

RULES (CRITERIA)	PLAN OF CORRECTION PART 1	Completion Date
<input checked="" type="checkbox"/> §11-100.1-13 Nutrition. (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit. FINDINGS Resident #2—No documentation of an annual diet order signed by resident's physician or APRN. <i>Please provide documentation with your plan of corrections (POC).</i>	<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;"><i>Checked. Copy on record.</i></p>	<p style="text-align: center;">3-21¹¹-2024 84</p>

STATE OF MARYLAND
 DEPARTMENT OF HEALTH
 DIVISION OF LICENSING
 26 MAY -6 P2:05

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-13 <u>Nutrition.</u> (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit. FINDINGS Resident #2—No documentation of an annual diet order signed by resident's physician or APRN.	<p style="text-align: center;">PLAN OF CORRECTION PART 2 <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;"><i>will write a note in the calendar to remind before the expiration.</i></p>	<p style="text-align: center;">3-27-2026 11:24</p> <p style="text-align: center;">MAY -6 PM:05</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> § 11-100.1-17 Records and reports. (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; FINDINGS Resident #2—No record of an annual physical exam was done. <i>Please provide documentation with your plan of corrections (POC).</i>	<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;"><i>Corrected. Copy enclosed.</i></p>	<p style="text-align: center;"><i>3-11-2026</i></p>

STATE OF MICHIGAN
MAY -6 2026 P2:05

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-17 Records and reports, (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; FINDINGS Resident #2—No record of an annual physical exam was done.	<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;"><i>will write a note in the calendar to remind before the expiration.</i></p>	<p style="text-align: center;"><i>3-11-2026</i></p>

STATE OF MARYLAND
 STATE LICENSING

26 MAY -6 P2:06

Licensee's/Administrator's Signature: Re A. Garcia

Print Name: Fe A. Garcia

Date: May 4, 2024

SMC
STATE LICENSING
MAY -6 P2:06