

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Giovannie Senior Living, LLC	CHAPTER 100.1
Address: 1352 Molehu Drive, Honolulu, Hawaii 96818	Inspection Date: April 29, 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
☒	§11-100.1-3 <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 care giver (SCG) #4 – Only Fieldprint result (APS, CAN, Fingerprints) 5/30/23 was available. Does not meet DOH background requirements.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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☒	§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 care giver (SCG) #4 – Only Fieldprint result (APS, CAN, Fingerprints) 5/30/23 was available. Does not meet DOH background requirements.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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> SCG #1 – There was TB Document F form for annual TB clearance but not dated. The date was confirmed during the inspection. SCG #2 – No annual TB clearance.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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> SCG #2 and #3 – No initial TB clearance.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-10 <u>Admission policies.</u> (g) An inventory of all personal items brought into the Type I ARCH by the resident shall be maintained. <u>FINDINGS</u> Resident #2 – Personal items brought to care home was not recorded.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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☒	§11-100.1-10 <u>Admission policies.</u> (g) An inventory of all personal items brought into the Type I ARCH by the resident shall be maintained. <u>FINDINGS</u> Resident #2 – Personal items brought to care home was not recorded.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

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☒	§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. <u>FINDINGS</u> Resident #2 – Diet order 4/28/26 was “full diet.” This is not a standard order. Please clarify with physician.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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☒	§11-100.1-14 <u>Food sanitation.</u> (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies. <u>FINDINGS</u> A padlock with long shackle was used for under sink cabinet in kitchen. The cabinet doors could be opened wide enough without unlocking the padlock. Cleaning supplies and bleach bottle were stored inside. Corrected during the inspection.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

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☒	§11-100.1-15 <u>Medications.</u> (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. <u>FINDINGS</u> Chlorhexidine Gluconate Oral Rinse, USP was left in resident's bathroom #2.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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☒	§11-100.1-17 <u>Records and reports.</u> (a)(1) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Documentation of primary care giver's assessment of resident upon admission; <u>FINDINGS</u> Resident #2 – Admission assessment was not signed by resident/family at admission.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

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☒	§11-100.1-17 <u>Records and reports.</u> (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; <u>FINDINGS</u> Resident #1 – No annual TB clearance.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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☒	§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; <u>FINDINGS</u> Resident #2 – There were no progress notes.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

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☒	§11-100.1-17 <u>Records and reports.</u> (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; <u>FINDINGS</u> One respite resident was not recorded in permanent resident register. Diagnoses/referred by were not recorded for one current resident.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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☒	§11-100.1-21 <u>Residents' and primary care givers' rights and responsibilities.</u> (a)(1)(A) Residents' rights and responsibilities: Written policies regarding the rights and responsibilities of residents during the stay in the Type I ARCH shall be established and a copy shall be provided to the resident and the resident's family, legal guardian, surrogate, sponsoring agency or representative payee, and to the public upon request. The Type I ARCH policies and procedures shall provide that each individual admitted shall: Be fully informed orally or in writing, prior to or at the time of admission, of these rights and of all rules governing resident conduct. There shall be documentation signed by the resident that this procedure has been carried out; <u>FINDINGS</u> Resident #2 – Care home policy was not signed by primary care giver (PCG). Corrected during the inspection.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____