Office of Health Care Assurance

'25 MAR 17 P1

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Aloha ARCH	**CHAPTER 100.1**
Address: **86-107 Hoaha Street, Waianae, Hawaii 96792**	**Inspection Date: December 17, 2024 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 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 Care Giver (SCG) #1 – No documented evidence stating that the above care giver has no prior felony or abuse convictions in a court of law on file.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Field Print was scheduled and completed for SCG #1 Please see attached Fitness Determination for SCG #1 fitness determination date 01/07/2025 showing that SCG #1 received a green light determination.	12/30/2025 1/7/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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** SCG #1 – No documented evidence stating that the above care giver has no prior felony or abuse convictions in a court of law on file.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** A checklist was created to ensure that all requirements, including documented evidence stating that the licensee, primary care giver, family members living in the facility that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse conviction in a court of law. This checklist will be completed by thePCG, SCG, or CHO. and double checked by PCG, SCG or CHO. It will be kept in the Care Home Folder at all times. Please see attached checklist for Personnel, Staffing and family members.	12/18/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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 "Artificial Tears" eye drops on 11/20/2024. Medication is not available in facility for resident use.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** SCG retrieved the Artificial Tears eye drop from Resident #1 as soon he returned home and immediately returned it to the container with the rest of his eye drops. CHO obtained a physician order for self administration for Resident #1 for the above eye drop.	12/17/2024

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☒	§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 "Artificial Tears" eye drops on 11/20/2024. Medication is not available in facility for resident use.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Created an In/Out Log to document that the medication that the resident is allowed to self-administer, is in the resident's possession and not missing from the medication bin. This log includes the resident's name, medication details, the date the medication was given to the resident for self-administration and the date the medication was returned to the medication bin. A copy of the physician's order for self-administration will be attached to the mdeication In/Out Log. The In/Out Log will be kept with the Medication Administration record. The primary or substitute caregiver will check daily to make sure that any medication given to the resident for self administration is still in the resident's possession or returned to the medication bin.	'25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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 #1, Resident #2, Resident #3, Resident #4, Resident #5 – No documented evidence of a current annual level of care evaluation by a physician or advanced practice registered nurse (APRN) on file.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** CHO immediately completed the most recent form "Resident Annual Examination Record" which includes Level of Care Assessment" for Residents #1, #2, #3, #4, #5. Obtained signature from each respective physician/APRN. Please see attached forms for all residents.	12/18/25

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Licensee's/Administrator's Signature: Marilyn Acuram

Print Name: MARILYN ACURAM

Date: 3/15/25

Licensee's/Administrator's Signature: Marlyn Acuran

Print Name: MARLYN ACURAN

Date: 4/15/25