Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Maestro Care Home II	**Chapter:** 100.1
Address: 141 Hoomalu Street, Pearl City, Hawaii 96782	**Inspection Date:** June 3, 2026 Relicensing Inspection

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. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE WITHOUT YOUR RESPONSE.

RULE (CRITERIA)	PLAN OF CORRECTION	Completion Date
§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:** PF-02 - Substitute Care Giver #1 - No current certification for first aid.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

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RULE (CRITERIA)	PLAN OF CORRECTION	Completion Date
§11-100.1-14 Food sanitation. (a) All food shall be procured, stored, prepared and served under sanitary conditions. **FINDINGS:** Observed bottled waters stored directly on the kitchen floor. 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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RULE (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 order dated 05/08/2026 stated, "Lactulose 10 g/15ml liquid 15 milliliter orally 2 times a day, PRN constipation," however, medication was not available at the care home.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

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RULE (CRITERIA)	PLAN OF CORRECTION	Completion Date
§11-100.1-23 Physical environment. (g)(3)(I)(i) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self- preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either: For each such non-certified resident there must be a responsible adult on the premises of the home at all times that the non-certified resident is present in the home, and there must never be a stairway which must be negotiated for emergency exit by such non-certified resident; **FINDINGS:** Residents #1, #2, #3, and #4 - Four (4) residents residing in the care home were non-certified (non-self-preserving) by their physicians, which is above the	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

limit of two (2) for the care home. Please discharge two (2) residents from your care home within 30 days. Please send a copy of your care home register with your plan of correction.		

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§11-100.1-23 Physical environment. (j)(1) Waste disposal: Every Type I ARCH shall provide a sufficient number of watertight receptacles, acceptable to the department for rubbish, garbage, refuse, and other matter. These receptacles shall be kept closed by tight fitting covers; **FINDINGS:** The residents bathroom contained a garbage receptacle that was not kept closed by a tight-fitting lid. 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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RULE (CRITERIA)	PLAN OF CORRECTION	Completion Date
§11-100.1-83 Personnel and staffing requirements. (1) In addition to the requirements in subchapter 2 and 3: A registered nurse other than the licensee or primary care giver shall train and monitor primary care givers and substitutes in providing daily personal and specialized care to residents as needed to implement their care plan; **FINDINGS:** Substitute Care Giver #1 - No documented evidence of training, provided by the RN case manager, in the care of an expanded level resident.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

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Licensee’s/Administrator’s Signature:

Print Name:

Date: