

Office of Health Care Assurance

7/1/25 1:12

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Mildred's	CHAPTER 100.1
Address: 94-1273 Peke Place, Waipahu, Hawaii 96797	Inspection Date: March 3, 2025 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> House Hold Member (HHM) #1 – No documented evidence that HHM has no prior felony or abuse convictions in a court of law on file for department review.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY <i>yes, corrected w/ appointment made, (see attached appt.) scheduled</i>	5/3/25

	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> HHM #1 – No documented evidence that HHM has no prior felony or abuse convictions in a court of law on file for department review.	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? <i>Will review & update all household members & staff regarding fingerprint requirement created a checklist as reminder or put a note on the chart. Result will mail upon availability</i>	<i>5/3/25</i>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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 #3 – Physician ordered, "Regular, low salt, low sugar" diet. Diet order not specific if resident requires a special diet as diet order, as written, is both a regular diet and special diet.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY <i>Diet is clarified & corrected specify diet of the resident from PCP</i>	<i>5/3/25</i>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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 #3 – Physician ordered, "Regular, low salt, low sugar" diet. Diet order not specific if resident requires a special diet as diet order, as written, is both a regular diet and special diet.	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? <i>TO prevent from happening again I will put a note or sticker on the chart to remind me to check orders written by PCP or for needed clarification.</i>	<i>5/3/25</i> <i>6-10-25</i>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-19 <u>Resident accounts.</u> (d) An accurate written accounting of resident's money and disbursements shall be kept on an ongoing basis, including receipts for expenditures, and a current inventory of resident's possessions. <u>FINDINGS</u> Resident #4 – No documented evidence of a current inventory of belongings on file. Last documented inventory of residents' belongings dated 2023.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY yes, corrected & I made sure that I updated my inventory to current belongings my resident brought to my care home (see attached checklist)	5/3/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-19 <u>Resident accounts.</u> (d) An accurate written accounting of resident's money and disbursements shall be kept on an ongoing basis, including receipts for expenditures, and a current inventory of resident's possessions. <u>FINDINGS</u> Resident #4 – No documented evidence of a current inventory of belongings on file. Last documented inventory of residents' belongings dated 2023.	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? <i>In the future to prevent from happening again I made a checklist to make sure I will record belongings for resident brought by family family.</i>	5/3/25

Licensee's/Administrator's Signature: Mildred

Print Name: Mildred Bumanglag

Date: Mar 6, 2025

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STILLSON

Licensee's/Administrator's Signature: Mildred Bumanglag

Print Name: MILDRED BUMANGLAG

Date: 5/3/25

25 MAY 2025