

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Ugalino ARCH	CHAPTER 100.1
Address: 1017 Ehoeho Avenue, Wahiawa Hawaii, 96786	Inspection Date: September 26, 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. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	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 #2: No documented evidence of fieldprint background check.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY <i>I did corrected this deficiency asking to my substitute caregiver on her fieldprint document. I ask her to key September 28, 2024. copy of document is enclosed.</i>	11/1/2024

	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 #2: No documented evidence of fieldprint background check.	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? The primary Care Giver has created a check list with all care giver requirements which includes fieldprint background checks. This checklist will be reviewed by the PCG quarterly and a reminder will be placed on the front of my carehome binder, as well as written on my calendar so I do not forget to check.	2/18/25

	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> House hold member #1: No documented evidence of fieldprint background check.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY <i>I ask to my household member to go get her criminal history check, background history check she did go on 10-10-2024. yes, I did correct the deficiency.</i>	24 NOV -4 12:04 11/1/2024

	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 #1: No documented evidence of fieldprint background check.	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>The PCG has created a check list with all house hold member requirements which include Fieldprint background checks. The checklist will be reviewed by the PCG quarterly and a reminder will be placed on the front of my care home binder as well as written on my calendar as I do not forget to check.</i>	2/18/25

	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> Substitute care giver #1: No documented evidence of annual tuberculosis clearance.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY <i>I corrected this deficiency asking for my #1 substitute caregiver to get the attestation screening form for the tuberculosis clearance. This was done on 10/11/2024.</i>	74 1001 -4 P2 04 10-11-2024

	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> Substitute care giver #1: No documented evidence of annual tuberculosis clearance.	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? The PCG has made a list of all care givers and required care giver clearances with their expiration dates. This list will be placed in the front of the care home binder. The checklist and supporting documents will be reviewed by the PCG every quarter to ensure all clearances are available and current. A reminder has been placed on my calendar to ensure the clearances are in fact reviewed every quarter.	2/18/25

	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> Resident #1: No documented evidence of annual tuberculosis clearance.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY <i>I did corrected this deficiency bringing my resident #1 for TB Test done on 10/10/24.</i>	24 NOV -4 P2 04 STATE 10-10-2024

	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> Resident #1: No documented evidence of annual tuberculosis clearance.	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? The PCG has made a list of all residents and required residents clearances with their expiration dates. This list will be placed in the front of the care home binder. The checklist and supporting documents will be reviewed by the PCG every quarter to ensure all clearances are available and current. A reminder has been placed on my calendar to ensure the clearances are in fact reviewed every quarter.	75 FEB 21 2/18/25

	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. FINDINGS Resident #3: No documented evidence of annual tuberculosis clearance.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY <i>I did correct this deficiency bringing my resident #3 for her TB test done on 10/10/2024.</i>	'24 NOV -4 P2:04 823 87

	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> Resident #3: No documented evidence of annual tuberculosis clearance.	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? The PCG has made a list of all residents and reviewed residents clearances with their expiration dates. This list will be placed in the front of the care home binder. The checklist and supporting documents will be reviewed by the PCG every quarter to ensure all clearances are available and current. A reminder has been placed on my calendar to ensure the clearances are in fact reviewed every quarter.	25 FEB 21 2/18/25

Licensee's/Administrator's Signature: Josefina Ugalino

Print Name: Josefina Ugalino

Date: 11/1/2024

24 NOV -4 P 2:05
SEP 1 2024
SHELDON, IA

Licensee's/Administrator's Signature: Josefin Ugalino

Print Name: Josefin Ugalino 25 FEB 21 10:15

Date: 2/18/2025

STATE