STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Riingen ARCH/Expanded ARCH	**CHAPTER 100.1**
Address: **17-559 Ipuaiwaha Street, Keaau, Hawaii 96749**	**Inspection Date: October 12, 2021 – 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
☒	§11-100.1-2 Definitions. As used in this chapter: "Licensed capacity" means the number of residents and the type of residents permitted by the director, pursuant to these rules and chapter 321, HRS, in a particular ARCH or expanded ARCH, and so stated on the particular ARCH's or expanded ARCH's license. **FINDINGS** Permanent general register reflected the following: George William Dunn – 03/23/19 – 01/01/21 John Mulford – 03/16/20 – 10/12/20 Candice Koi – 05/14/15 – present Kinuyo Isemoto – 12/15/14 - present Florence Figueira – 04/24/20 – present Bernice Oshiro – 01/04/21 (10/01/20) – present Six (6) residents between 10/01/20 – 10/12/20. This facility is licensed as a Type 1 ARCH/Expanded ARCH for five (5) or less residents.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-2 Definitions. As used in this chapter: "Licensed capacity" means the number of residents and the type of residents permitted by the director, pursuant to these rules and chapter 321, HRS, in a particular ARCH or expanded ARCH, and so stated on the particular ARCH's or expanded ARCH's license. **FINDINGS** Permanent general register reflected the following: George William Dunn – 03/23/19 – 01/01/21 John Mulford – 03/16/20 – 10/12/20 Candice Koi – 05/14/15 – present Kinuyo Isemoto – 12/15/14 - present Florence Figueira – 04/24/20 – present Bernice Oshiro – 01/04/21 (10/01/20) – present Six (6) residents between 10/01/20 – 10/12/20. This facility is licensed as a Type 1 ARCH/Expanded ARCH for five (5) or less residents.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this issue in the future, all admission records will be reviewed for signatures at dates for accuracy, upon completion of admission record.	11/10/21

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (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. **FINDINGS** Resident #1 – admitted 10/01/20, diet order written 10/08/20.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** Resident was admitted on 11/01/2021. Records show 10/01/2020. Records were corrected & updated - incorrect date was also crossed out, dated & documented as an error, as is protocol & the correct date was documented. Therefore, the diet was written before the admission.	11/14/2021

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☒	§11-100.1-13 Nutrition. (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. **FINDINGS** Resident #1 – admitted 10/01/20, diet order written 10/08/20.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this issue in the future, all admission records will be reviewed for signatures et dates for accuracy, upon completion of admission-records.	11/14/2021

	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 order dated 10/30/20 read: • D/C "Cholecalciferol (Vitamin D3) 800 units PO daily" • D/C "Lidocaine 5% 1 applic. Topical daily" However, medications/treatments were listed on the November 2020 medication record and discontinued on 11/09/20.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** 1- 10/08/2020- Medications ordered- by Doctor. A. Moore 2- 10/30/2020- Dr. F. Steele - drew a line across these meds without writing "dc" and initialing, Caregiver Continued the meds. 3- 11/09/2020- Medication orders clarified and discontinued.	11/14/2021

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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 order dated 10/30/20 read: • D/C "Cholecalciferol (Vitamin D3) 800 units PO daily" • D/C "Lidocaine 5% 1 applic. Topical daily" However, medications/treatments were listed on the November 2020 medication record and discontinued on 11/09/20.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this issue in the future, all incomplete orders will be clarified, and orders documented accurately. All persons to acknowledge accuracy of the orders by reading back the orders to the physician.	11/14/2021

	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 – January 2020 medication record reflected the following medication initialed as administered beginning 01/14/21: • "Quetiapine 100 mg 1 tablet by mouth daily" • "Quetiapine 25 mg oral everyday at bedtime – D/C" However, physician order was dated 01/24/21.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** 1- 01/14/2021- Quetiapine 100 mg 1 tablet by mouth daily, Quetiapine 25 mg oral every day at bedtime (last dose given 01/13/2021 at HS)- Also, caregiver was contacted by the pharmacy to pick up the meds, that was called in to the pharmacy, without notifying the caregiver. 2- on 01/14/2021- Resident refused to take the medicine when administered- "You guys are overdozing me. MD notified and gave a phone order to stop the medicines. 3- All the orders were submitted to the physician & she dated it on that day she recieved the paperwork (01/24/2021) without any documentation to the original date of the order. 11/14/2021	

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	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 – May 2021 medication record reflected the following medication initialed as administered beginning 05/05/21: • "Citalopram HBR 10 mg/5 ml Soln take 2.5 ml by mouth everyday." However, physician order was dated 05/27/21.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** 4/30/21 - Physician discussed possibility of starting resident on Citalopram at office visit, but wanted to clear it with another colleague, related to recent behaviors. 5/1/2021 - Pharmacy called - Med not available, will have to be ordered, physician called pharmacy. 5/5/21 - Pharmacy called med available et med started. Order obtained from physician. Signed off on the date received on his desk. 5/27/2021.	11/14/2021

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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 – May 2021 medication record reflected the following medication initialed as administered beginning 05/05/21: • "Citalopram HBR 10 mg/5 ml Soln take 2.5 ml by mouth everyday." However, physician order was dated 05/27/21.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this issue in the future, when receiving all new meds orders/medications given by phone or other healthcare providers, after clarifying the orders with the MD, by phone call: 1- I will document the date at time along with the orders itself, on the day I recieved it and document that it was a phone order on the physicians' order form. 2- This physician order form will be taken to the physician for the confirmation of the orders given on the day that I documented, within the required time, for the physicians' signature.	11/14/2021

	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 – January 2021 medication record reflected the following medication initialed as administered beginning 01/01/21: • "Losartan 50 mg PO daily" However, physician order was dated 01/27/21.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** ? MD Staff verbalized to allow M.D... to sign off the orders when taken to his office, until the next office visit. Orders were finally sign on 01/27/2021	11/04/2021

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	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 order dated 07/22/21 read: • "CVS Melatonin 5mg softgel take 1 capsule by mouth at bedtime" However, medication initialed as administered 07/01/21 – 07/31/21.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** Medication was d/c'd on 5/27/2021- Resident refused to take. Medication was listed on the new MARs in error. Medication was not given, medication was disposed of appropriately, when med d/c'd.	11/14/2021

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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 order dated 08/25/21 read: • "D/C Melatonin" However, August and September 2021 medication record initialed as administered 08/01/21 – 09/30/21.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** Orders were presented to the physician on a pre-printed order sheet, which included the Melatonin order in error. MD noted that order at dc'd it on the 08/25/2021 visit	11/14/2021

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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 order dated 08/25/21 read: • "D/C Melatonin" However, August and September 2021 medication record initialed as administered 08/01/21 – 09/30/21.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this happening again as soon as the medication DC put the line and put the date DC and up date the MR and initial it. The following month i will double check the current Doctor order when transcribing medications to the new month.	01-13-22

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. **FINDINGS** Resident #1 – admitted on 10/01/20, no October 2020 medication record.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** Resident was admitted on 11/01/2020 - Records show 10/01/2020 - Records were corrected et updated - incorrect date was crossed out, dated et documented as an error, as is protocal et the correct date was documented.	11/24/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. **FINDINGS** Resident #1 – admitted on 10/01/20, no October 2020 medication record.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this issue in the future, all admission records will be reviewed for signatures & dates for accuracy, upon completion of admission records.	11/14/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (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; **FINDINGS** Resident #1 – admitted 10/01/20, admission assessment completed on 11/01/20.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** Resident was admitted on 11/01/2020 - Records show 10/01/2020 - Records were corrected & updated - incorrect date was crossed out, dated & documented as an error, as is protocol & the correct date was documented.	11/14/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (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; **FINDINGS** Resident #1 – admitted 10/01/20, admission assessment completed on 11/01/20.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this issue in the future, all admission records will be reviewed for signatures & dates for accuracy, upon completion of admission records.	11/14/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(4) 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: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident #1 – admitted 10/01/20, single tuberculosis (TB) skin test completed prior to admission (01/02/21). No two (2) step TB skin test.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** When i admitted the resident Obtain the step II PPD and dated 01-02-20 but not attach to the Physical form record upon Admission. i filed in the Vaccination record and Physical form.	01-13-22

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☒	§11-100.1-17 Records and reports. (a)(4) 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: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident #1 – admitted 10/01/20, single tuberculosis (TB) skin test completed prior to admission (01/02/21). No two (2) step TB skin test.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this issue, all admissions will be screened for 2 step TB tests as part of an admission checklist.	11/14/2021

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☒	§11-100.1-17 Records and reports. (a)(4) 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: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident #1 – admitted 10/01/20, physical examination completed after admission on 10/08/20.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** Resident was admitted on 11/01/2020. Records show 10/01/2020. Records were corrected & updated incorrect date was crossed out, dated & documented as an error, as is protocal & the correct date was documented.	11/14/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(4) 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: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident #1 – admitted 10/01/20, physical examination completed after admission on 10/08/20.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this issue in the future, all admission records will be reviewed for signatures & dates for accuracy, upon completion of admission records.	11/14/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(8) 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: A current inventory of money and valuables. **FINDINGS** Resident #1 – admitted on 10/01/20, inventory of belongings completed on 11/01/20.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** Resident was admitted on 11/01/2020 - Records show 10/01/2020 - Records were corrected at updated - incorrect date was crossed out, dated & documented as an error, as is protocol & the correct date was documented.	11/14/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(8) 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: A current inventory of money and valuables. **FINDINGS** Resident #1 – admitted on 10/01/20, inventory of belongings completed on 11/01/20.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this issue in the future, all admission records will be reviewed for signatures & dates for accuracy, upon completion of admission records.	11/14/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary. **FINDINGS** Resident #1, no incident reports for the following: • 01/24/21 – Emergency department visit for "vasovagal syncope, dehydration and constipation"	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Incident was completed but was filed at the back of the binder. Form was filed appropriately.	11/14/2021

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☒	§11-100.1-17 Records and reports. (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary. **FINDINGS** Resident #1, no incident reports for the following: • 01/24/21 – Emergency department visit for "vasovagal syncope, dehydration and constipation"	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the future i will not file it in the back of my resident folder and to avoid this i have to not happening again i will file the incident report to my incident folder as soon as made the incident report when the ~~day~~ same day. My substitute will be check to make sure is file correctly.	01-13-22

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☒	§11-100.1-17 Records and reports. (f)(4) General rules regarding records: All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency. **FINDINGS** Resident #1 – resident emergency information sheet was not updated to reflect current TB skin test, physician and current medications.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** form were attached. "See Attached" was noted on the Residents' Emergency Information sheet, to indicate sheets attached.	11/14/2021

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☒	§11-100.1-17 Records and reports. (f)(4) General rules regarding records: All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency. **FINDINGS** Resident #1 – resident emergency information sheet was not updated to reflect current TB skin test, physician and current medications.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this issue in the future, when attaching records to the Residents' Emergency Information Sheet, it will be indicated on the Residents' Emergency Information sheet.	11/14/2021

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☒	§11-100.1-17 Records and reports. (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** Resident #1 – permanent general register reflected admission date of 01/04/21. However, October 2020 progress note dated 10/01/20 read, "1:30 pm 83 yo Female admitted to my care home via private car accompanied by POA DTR. . . . ." 10/03/20 – 4 pm sitting outside asked everybody to take her home." 10/04/20 – "0500 awake always on her cell phone calling everybody." 10/09/20 – "2:30 pm appointment with Dr. A. Moore" Permanent general record and progress notes contain conflicting dates.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Admission date recorded incorrectly 01/04/21. Correct admission date is 11/01/2020. Records were corrected at updated – incorrect date was crossed out, dated at documented as an error, as is protocol at the correct date was documented.	11/14/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** Resident #1 – permanent general register reflected admission date of 01/04/21. However, October 2020 progress note dated 10/01/20 read, "1:30 pm 83 yo Female admitted to my care home via private car accompanied by POA DTR. . . . ." 10/03/20 – 4 pm sitting outside asked everybody to take her home." 10/04/20 – "0500 awake always on her cell phone calling everybody." 10/09/20 – "2:30 pm appointment with Dr. A. Moore" Permanent general record and progress notes contain conflicting dates.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this issue in the future, all admission records will be reviewed for signatures & dates for accuracy, upon completion of admission records.	11/14/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-19 Resident accounts. (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative. **FINDINGS** Resident #1, admitted on 10/01/20, financial statement signed 10/28/20.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** Actual Admission date is 11/01/2020- Financial statement sign 10/28/2020, resident was admitted 11/01/2020- DTR needed to sign records, because she lives off Island and needed to leave before the admission date. Admission date was listed incorrectly.	11/14/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-19 Resident accounts. (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative. **FINDINGS** Resident #1, admitted on 10/01/20, financial statement signed 10/28/20.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this issue in the future, all admission records will be reviewed for signature at dates for accuracy, upon completion of admission records.	11/14/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (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; **FINDINGS** Resident #1 – admitted on 10/01/20, general operational policy signed 10/28/20.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.** Actual admission date is 11/01/2020 - General Operational Policy signed 10/28/2020, resident was admitted 11/01/2020 - DTR needed to sign records, because she lives off island and needed to leave before the admission date. Admission date was listed incorrectly	11/14/2021

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (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; **FINDINGS** Resident #1 – admitted on 10/01/20, general operational policy signed 10/28/20.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To avoid this issue in the future, all admission records will be reviewed for signatures & dates for accuracy, upon completion of admission records.	11/14/2021

Licensee's/Administrator's Signature: Benita Riingen

Print Name: BENITA RIINGEN

Date: 11/14/2021

Licensee's/Administrator's Signature Benita Ringen

Print Name: BENITA RINGEN

Date: December 31, 2021

Licensee's/Administrator's Signature: Benita Riingen

Print Name: BENITA RIINGEN

Date: 01-13-22