

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: 888 Adult Residential Care Home	CHAPTER 100.1
Address: 98-550 Kaamilo Street, Aiea, Hawaii 96701	Inspection Date: June 6, 2022 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) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

22 AUG -4 PM 12:17
STATE OF HAWAII
DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE ASSURANCE

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>. (b)(1)(I) Application.</p> <p>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:</p> <p>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;</p> <p><u>FINDINGS</u> Household member #1 – No 2022 Fieldprint result.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>— Household member #1 Fieldprint result has been filed and corrected.</i></p>	<p style="text-align: center;"><i>8/07/22</i></p> <p style="text-align: center;">22 AUG -4 PM 2:17</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>. (b)(1)(I) Application.</p> <p>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:</p> <p>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;</p> <p><u>FINDINGS</u> Household member #1 – No 2022 Fieldprint result.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>- In the future to prevent this deficiency from happening. I will post a note to the calendar to get updated on time.</i></p>	<p>22 AUG -4 PM 12:18</p> <p>STATE OF ILLINOIS DEPARTMENT OF CHILDREN & PARENTS STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p><u>FINDINGS</u> Substitute Care Giver (SCG) #1 and Household member #1 – No current physical exam.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>– SCG #1 and Household member #1 was sent to see their primary doctor to get their physical exam. Records are corrected and on file.</i></p>	<p style="text-align: right;">22 AUG -4 P12:18</p>

STATE OF NEW YORK
HOSPITAL
STATE LICENSING

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p><u>FINDINGS</u> Substitute Care Giver (SCG) #1 and Household member #1 – No current physical exam.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>- In the future to prevent this deficiency from happening. I will post a note to the calendar to get updated on time.</i></p>	<p><i>8/6/22</i></p> <p style="text-align: right;">22 AUG -4 PM 2:18</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p><u>FINDINGS</u> SCG #2 – No 2-step tuberculosis clearance.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>- SCG #2 was sent to see his primary doctor to get his 2 step tuberculosis clearance done. Record was received and filed.</i></p>	<p><i>8/3/22</i></p> <p style="text-align: right;">22 AUG -4 PM 2:18</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p><u>FINDINGS</u> SCG #2 – No 2-step tuberculosis clearance.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>- In the future to prevent this deficiency from happening. I will post a note to the calendar to get updated on time.</i></p>	<p>22 AUG -4 P12:18</p> <p>STATE OF NEW JERSEY 05/16/2024 STAFF LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Glucosam-chond-hyalu-CF borate (MOVE FREE JOINT HEALTH) 750mg-100mg-1.65mg-108mg oral tab was ordered on 4/29/2022. Medication available was "MOVE FREE ULTRA TRIPLE ACTION (BORON) 40mg-5mg-3.3mg tab, take 1 tablet by mouth daily." Please clarify with physician.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Resident #1 - Glucosam-chond-hyalu - CF borate (Move Free Joint Health) 750mg - 100mg - 1.65mg - 108mg oral tab was ordered on 4/29/2022 was clarified with the physician. The medication was the removed and medication move free ultra triple action (Boron) 40mg - 5mg - 3.3mg is continued and ordered.</i></p> <p>STATE OF FLORIDA DEPARTMENT OF STATE LICENSING</p>	<p>22 AUG -4 PM 2:18</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Glucosam-chond-hyalu-CF borate (MOVE FREE JOINT HEALTH) 750mg-100mg-1.65mg-108mg oral tab was ordered on 4/29/2022. Medication available was “MOVE FREE ULTRA TRIPLE ACTION (BORON) 40mg-5mg-3.3mg tab, take 1 tablet by mouth daily.” Please clarify with physician.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>-In the future to prevent this deficiency from happening. I will double check all medication every time the resident will visit his/her doctor's appointment. I will make sure all medication is up to date with the doctor's record.</i></p>	<p><i>6/4/22</i></p> <p style="text-align: right;">22 AUG -4 P12:18</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Loratadine 10mg 1 tab, qd, PRN for allergy symptoms was ordered on 4/29/2022. No medication available.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Resident #1 - Loratadine 10mg 1 tab, qd PRN for allergy symptoms was ordered refill and now added on the residents medication.</i></p>	<p style="text-align: right;"><i>6/3/22</i></p> <p style="text-align: right;">22 AUG -4 PM 2:18</p> <p style="text-align: right;">STATE OF IOWA DOH/CHS STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Loratadine 10mg 1 tab, qd, PRN for allergy symptoms was ordered on 4/29/2022. No medication available.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>- In the future to prevent this deficiency from happening. I will check all medication and make sure are all refilled every time we distribute medication to the residents.</i></p>	<p><i>6/7/22</i></p> <p style="text-align: right;">22 AUG -4 PM 12:18</p> <p style="text-align: right;">STATE OF NEW YORK DEPARTMENT OF HEALTH STATE LICENSED</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (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.</p> <p><u>FINDINGS</u> Resident #1 – “Cartilage-Collagen-bor-hyalur 40-5-3.3mg oral tab, take 1 tablet by mouth daily” was listed in physician’s order 3/18/2022. Not listed in medication administration record (MAR).</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>- Resident #1 - Cartilage - Collagen - bor-hyalur 40.5-3.3mg oral tab, taken 1 tablet by mouth daily was clarified with the doctor and must add to the medication list or “MAR”. Medication is now on the MAR list and ordered.</p> <p style="text-align: right; font-size: small;">STATE OF NEW YORK DEPARTMENT OF SOCIAL SERVICES</p>	<p style="text-align: center;">8/3/22</p> <p style="text-align: right;">22 AUG -4 PM 2:18</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p><u>FINDINGS</u> Resident #1 – “Cartilage-Collagen-bor-hyalur 40-5-3.3mg oral tab, take 1 tablet by mouth daily” was listed in physician’s order 3/18/2022. Not listed in medication administration record (MAR).</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>-In the future to prevent this deficiency from happening. I will double check with the doctor's medication list for the resident every visit.</i></p>	<p style="text-align: right;"><i>8/3/22</i></p> <p style="text-align: right;">22 AUG -4 PM 2:18</p> <p style="text-align: right; transform: rotate(-90deg);">STATE OF HAWAII DEPARTMENT OF SOCIAL SERVICES SMITHSONIAN</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p><u>FINDINGS</u> Resident #1 – Cephalexin (Keflex) 500mg oral cap, 1 cap by mouth 2 times a day for 5 days was ordered 5/20/2022. The medication was listed in MAR but dosage and frequency were not noted.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Resident #1 - Cephalexin (Keflex) 500 mg oral cap. 1 cap by mouth 2 times a day for 5 days was ordered 5/20/2022 is now inputted dosage and frequency on MAR.</i></p>	<p style="text-align: right;"><i>5/27/22</i></p> <p style="text-align: right;">22 AUG -4 PM 2:18</p> <p style="text-align: right;">STATE OF CONNECTICUT DEPARTMENT OF STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p><u>FINDINGS</u> Resident #1 – Cephalexin (Keflex) 500mg oral cap, 1 cap by mouth 2 times a day for 5 days was ordered 5/20/2022. The medication was listed in MAR but dosage and frequency were not noted.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future to prevent this deficiency from happening. I will make a notification in my MAR" list to make sure to fill in all the information needed upon received new orders.</i></p>	<p><i>6/7/22</i></p> <p>22 AUG -4 P12:19</p> <p>STATE OF CONNECTICUT JUDICIAL BRANCH STATE CLERK</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p><u>FINDINGS</u> Resident #1 – "Duloxetine (Cymbalta) 20mg oral CPDR SR 1 cap by mouth daily at bedtime" was increased to 30mg on 4/29/2022. In MAR it was noted "(4/29/2022 increased 30mg)." The same row as the previous order was used in MAR. A new entry for 20mg dosage was not made.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>- Resident #1 - "Duloxetine (Cymbalta) 20mg oral CPDR SR 1 cap by mouth daily at bedtime" was increased to 30mg on 4/29/2022. The medication 20mg dosage was the original dose then increased to 30mg was noted in the mar.</p>	<p>8/3/22</p> <p>22 AUG -4 PM 2:19</p> <p>STATE OF UTAH DEPARTMENT OF SOCIAL SERVICES STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p><u>FINDINGS</u> Resident #1 – “Duloxetine (Cymbalta) 20mg oral CPDR SR 1 cap by mouth daily at bedtime” was increased to 30mg on 4/29/2022. In MAR it was noted “(4/29/2022 increased 30mg).” The same row as the previous order was used in MAR. A new entry for 20mg dosage was not made.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future to prevent this deficiency from happening. I will change the MAR upon received changes medications to prevent confusion.</i></p>	<p><i>6/3/22</i></p> <p style="text-align: right;">22 AUG -4 PM 12:19</p> <p style="text-align: right; transform: rotate(-90deg);">STATE OF HAWAII DEPARTMENT OF HEALTH STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p><u>FINDINGS</u> Resident #1 – No legend for SCG #1's initial in MAR.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Resident #1 is now updated with a legend and signed by primary or substitute caregiver who ever distributing medication.</i></p>	<p><i>8/24/22</i></p> <p>22 AUG -4 PM 2:19</p> <p>STATE OF HAWAII DOH HHS STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p><u>FINDINGS</u> Resident #1 – No legend for SCG #1's initial in MAR.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>-In the future to prevent this deficiency from happening. I will make sure to get all Mar a legend and signed by PCG and SCG. I will double check every month to make sure all are signed and initialed.</i></p>	<p><i>8/14/22</i></p> <p>22 AUG -4 PM 2:19</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (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:</p> <p>Documentation of primary care giver's assessment of resident upon admission;</p> <p><u>FINDINGS</u> Resident #1 – No Primary Care Giver (PCG)'s admission assessment.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p> <p>STATE OF CONNECTICUT DEPT. OF REG. & LICENSING STATE LICENSING</p>	<p>6/2/22</p> <p>22 AUG -4 PM 2:19</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (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:</p> <p>Documentation of primary care giver's assessment of resident upon admission;</p> <p><u>FINDINGS</u> Resident #1 – No Primary Care Giver (PCG)'s admission assessment.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>- In the future to prevent this deficiency from happening I will make sure to do admission assessment upon admitting a resident by using the check list of records to be filled.</i></p>	<p><i>8/3/22</i></p> <p style="text-align: right;">'22 AUG -4 P12:19</p> <p style="text-align: right; transform: rotate(-90deg);">STATE OF CONNECTICUT DEPARTMENT OF STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (f)(4) General rules regarding records:</p> <p>All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency.</p> <p><u>FINDINGS</u> Resident #1 Emergency information sheet not up to date.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Resident #1 Emergency information sheet is now up to date and filed.</i></p>	<p><i>6/3/22</i></p> <p style="text-align: right;">'22 AUG -4 P12:19</p> <p style="text-align: right; transform: rotate(-90deg);">STATE OF HAWAII DEPARTMENT OF STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (f)(4) General rules regarding records:</p> <p>All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency.</p> <p><u>FINDINGS</u> Resident #1 Emergency information sheet not up to date.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future to prevent this deficiency from happening. I will fill up emergency information upon admission by using all my check list provided by the department to complete. And after doctors appointment.</i></p>	<p><i>6/7/22</i></p> <p>22 AUG -4 PM 2:19</p> <p>STATE OF MARYLAND DEPARTMENT OF CORRECTIONS SMITHSONIAN</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p><u>FINDINGS</u> Resident #1 – No financial agreement.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Resident #1 Financial agreement is now completed. It is been shown and explain to the family and resident. Records is on file and a copy is given to the family.</i></p>	<p><i>6/11/22</i></p> <p>22 AUG -4 PM 2:19</p> <p>STATE OF HAWAII DEPARTMENT OF STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p><u>FINDINGS</u> Resident #1 – No financial agreement.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future to prevent this deficiency from happening. I will discuss with the family and resident upon admission to complete and by using the list from the department to remind me.</i></p>	<p><i>8/3/22</i></p> <p>22 AUG -4 P12:19</p> <p>STATE OF IOWA BOB OLSON STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(1)(A)</p> <p>Residents' rights and responsibilities:</p> <p>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:</p> <p>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;</p> <p><u>FINDINGS</u> Resident #1 – Care home policies not signed and dated.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>The family of the resident has been signed.</i></p>	<p><i>6/7/22</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-21 <u>Residents' and primary care givers' rights and responsibilities.</u> (a)(1)(A) Residents' rights and responsibilities:</p> <p>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:</p> <p>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;</p> <p><u>FINDINGS</u> Resident #1 – Care home policies not signed and dated.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future to prevent this deficiency from happening. I will discuss it with the resident/family upon admission along with the rest of my admission check list provided by the department.</i></p>	<p><i>6/3/22</i></p> <p>22 AUG -4 PM 2:20</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(G) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Smoke detectors shall be provided in accordance with the most current edition of the National Fire Protection Association (NFPA) Standard 101 Life Safety Code, One and Two Family Dwellings. Existing Type I ARCHs may continue to use battery operated individual smoke detector units, however, upon transfer of ownership or primary care giver, such units shall be replaced with an automatic hard wiring UL approved smoke detector system;</p> <p><u>FINDINGS</u> No documentation that smoke detectors were tested in May 2022.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p> <p>STATE OF HAWAII BOH-011A STATE LICENSING</p>	<p>6/3/22</p> <p>22 AUG -4 PM 2:20</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(G) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Smoke detectors shall be provided in accordance with the most current edition of the National Fire Protection Association (NFPA) Standard 101 Life Safety Code, One and Two Family Dwellings. Existing Type I ARCHs may continue to use battery operated individual smoke detector units, however, upon transfer of ownership or primary care giver, such units shall be replaced with an automatic hard wiring UL approved smoke detector system;</p> <p><u>FINDINGS</u> No documentation that smoke detectors were tested in May 2022.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"> <i>- In the future to prevent this deficiency from happening. I will post a note on my calendar to remind the facility do fire drill every month.</i> </p>	<p style="text-align: right;">6/3/22</p> <p style="text-align: right;">*22 AUG -4 P12:20</p> <p style="text-align: center; transform: rotate(-90deg);">STATE OF NEW JERSEY DEPARTMENT OF COMMUNITY STATE DEPARTMENT</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (o)(1)(C) Bedrooms:</p> <p>General conditions:</p> <p>Family members shall not sleep in residents' bedrooms;</p> <p><u>FINDINGS</u> One household member was sleeping in licensed resident's bedroom #3</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Resident's bedroom #3 is now unoccupied. Every thing is clear and ready to use only for resident.</i></p>	<p><i>6/27/22</i></p> <p>22 AUG -4 P12:20</p> <p>STATE OF ILLINOIS DEPARTMENT OF HUMAN SERVICES</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (o)(1)(C) Bedrooms:</p> <p>General conditions:</p> <p>Family members shall not sleep in residents' bedrooms;</p> <p><u>FINDINGS</u> One household member was sleeping in licensed resident's bedroom #3</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>- In the future to prevent this deficiency from happening. I included in the house rules that no house members can use any of the resident's room for any thing.</i></p>	<p><i>6/7/22</i></p> <p>STATE OF HAWAII BOE-1100.1 STATE LICENSING</p> <p>22 AUG -4 PM 2:20</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(8) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Have face-to-face contacts with the expanded ARCH resident at least once every thirty days, with more frequent contacts based on the resident's needs and the care giver's capabilities;</p> <p><u>FINDINGS</u> Resident #1 – Most recent diet order was “Regular diet with thin liquids” dated 11/19/2021. Case manager’s monthly monitoring noted that resident is on soft diet, low salt, low cholesterol diet, thin liquids. Please clarify with the case manager.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>- Resident #1 diet order is been clarified with the case management that resident is on Regular diet with thin liquids only. Case management updated the records and change to the right order. and records are been filed.</i></p> <p style="text-align: right; font-size: small;">STATE OF MISSISSIPPI DEPARTMENT OF STATE LICENSING</p>	<p style="text-align: right;">22 AUG -4 PM 2:20</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(8) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Have face-to-face contacts with the expanded ARCH resident at least once every thirty days, with more frequent contacts based on the resident's needs and the care giver's capabilities;</p> <p><u>FINDINGS</u> Resident #1 – Most recent diet order was “Regular diet with thin liquids” dated 11/19/2021. Case manager’s monthly monitoring noted that resident is on soft diet, low salt, low cholesterol diet, thin liquids. Please clarify with the case manager.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future to prevent this deficiency from happening, I will have to double check with the case management every month to make sure she also putting the right orders.</i></p> <p style="text-align: right;"><i>6/14/22</i></p> <p style="text-align: right;">STATE OF HAWAII DEPT. OF HHS STATE LICENSING</p>	<p style="text-align: right;">22 AUG -4 PM 2:20</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(8) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Have face-to-face contacts with the expanded ARCH resident at least once every thirty days, with more frequent contacts based on the resident's needs and the care giver's capabilities;</p> <p>FINDINGS Resident #1 – Care plan was initialed and dated 5/13/2022 as reviewed by case manager. But no documentation for monthly monitoring for May 2022.</p>	<p align="center">PART 1</p> <p align="center"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p align="center">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>– Resident #1 Care plan and documentation for monthly monitoring for May 2022 was discussed with the case management. Case management shows on the documentation was on progress note.</i></p> <p align="right">STATE OF TEXAS HOSPITAL & STATE LICENSING</p>	<p align="right"><i>6/3/22</i></p> <p align="right">22 AUG -4 PM 2:20</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(8) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall:</p> <p>Have face-to-face contacts with the expanded ARCH resident at least once every thirty days, with more frequent contacts based on the resident's needs and the care giver's capabilities;</p> <p><u>FINDINGS</u> Resident #1 – Care plan was initialed and dated 5/13/2022 as reviewed by case manager. But no documentation for monthly monitoring for May 2022.</p>	<p align="center">PART 2</p> <p align="center"><u>FUTURE PLAN</u></p> <p align="center">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>In the future to prevent this deficiency from happening. I will have to double check with the case management documentation to make sure it's being done monthly and on time.</i></p> <p align="right">STATE OF PENNSYLVANIA DEPARTMENT OF STATE LIBRARIANSHIP</p>	<p align="right"><i>dh/rw</i></p> <p align="right">22 AUG -4 PM 12 20</p>

Licensee's/Administrator's Signature: Victor Laf. Jr

Print Name: Victor Laforteza Jr

Date: 8/3/22

STATE OF CALIFORNIA
BOAT-USA
STATE LICENSING

'22 AUG -4 P12:20