

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Ronidel Care Home	CHAPTER 100.1
Address: 94-407 Kahualena Street, Waipahu, Hawaii 96797	Inspection Date: November 3, 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.

	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>FINDINGS Substitute Care Giver (SCG) #1 – No initial/2 step tuberculosis clearance.</p> <p>Please submit a copy with your plan of correction (POC).</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 obtained the initial TB test SCG #1 and placed in the binder. See attached</p>	<p>1/3/23</p> <p>23 JAN -4 MO:21</p> <p>STATE OF HAWAII DEPARTMENT OF HEALTH 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> (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> Substitute Care Giver (SCG) #1 – No initial/2 step tuberculosis clearance.</p> <p>Please submit a copy with your plan of correction (POC).</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 will use SCG / Hm checklist to make sure I have all the SCG / Hm documents especially the TB clearance.</p>	<p>1/3/22</p> <p>23 JAN -4 AMO:21</p> <p>STATE OF ILLINOIS DEPARTMENT OF CORRECTIONS STATE LIAISON</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (a) Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be obtained prior to a resident's admission to a Type I ARCH and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's responsible placement agency, and others authorized by the resident to review it.</p> <p><u>FINDINGS</u> Resident #2 – No level of care.</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>The resident A 2 was discharge last 11/17/22. Unable to obtain current level of care.</p>	<p>11/31/23</p> <p>23 JAN -4 AMO:21</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (a) Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be obtained prior to a resident's admission to a Type I ARCH and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's responsible placement agency, and others authorized by the resident to review it.</p> <p><u>FINDINGS</u> Resident #2 – No level of care.</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>I will use the admission checklist to make sure I have all the documents needed like the level of care.</i></p>	<p><i>1/3/23</i></p> <p>23 JAN -4 AMO:21</p> <p>STATE OF OHIO DEPARTMENT OF STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (a) The Type I ARCH shall provide each resident with an appetizing, nourishing, well-balanced diet that meets the daily nutritional needs and diet order prescribed by state and national dietary guidelines. To promote a social environment, residents, primary care givers and the primary care giver's family members residing in the Type I ARCH shall be encouraged to sit together at meal times. The same quality of foods provided to the primary care givers and their family members shall be made available to the residents unless contraindicated by the resident's physician or APRN, resident's preference or resident's family.</p> <p><u>FINDINGS</u> Resident #2 – Physician's diet order 5/3/2022 was regular, pureed, thickened liquids with Thick it. Lunch meal consisted of Portuguese bean soup and green beans and was not pureed separately.</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>23 JAN -4 110:21</p> <p>STATE OF IDAHO DOH-611CA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (a) The Type I ARCH shall provide each resident with an appetizing, nourishing, well-balanced diet that meets the daily nutritional needs and diet order prescribed by state and national dietary guidelines. To promote a social environment, residents, primary care givers and the primary care giver's family members residing in the Type I ARCH shall be encouraged to sit together at meal times. The same quality of foods provided to the primary care givers and their family members shall be made available to the residents unless contraindicated by the resident's physician or APRN, resident's preference or resident's family.</p> <p><u>FINDINGS</u> Resident #2 – Physician's diet order 5/3/2022 was regular, pureed, thickened liquids with Thick it. Lunch meal consisted of Portuguese bean soup and green beans and was not pureed separately.</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>I will make sure to puree separately to follow the special diet - All care-givers to trained to puree separately.</i></p>	<p><i>1/3/23</i></p> <p>23 JAN -4 NO:21</p> <p>STATE OF NEW YORK BOH-EHCA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (l) Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets.</p> <p><u>FINDINGS</u> Resident #1 – Physician’s diet order 9/28/2022 was “Soft/Bite sized Thin Liquids.” The type of diet was not provided.</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>I obtained the new physicians diet order for resident #1 and place in the binder. See attached.</i></p>	<p><i>11/8/22</i></p> <p>23 JAN -4 NO -21</p> <p>STATE OF HAWAII DOH-CHCA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (l) Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets.</p> <p><u>FINDINGS</u> Resident #1 – Physician’s diet order 9/28/2022 was “Soft/Bite sized Thin Liquids.” The type of diet was not provided.</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 will make sure to use the diet checklist from the OCHA and have a new diet order from the doctor.</p>	<p>11/8/22</p> <p>23 JAN -4 AMO:21</p> <p>STATE OF NEW YORK DOH-ENCA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms.</p> <p><u>FINDINGS</u> Resident #1 – Physician's order 9/28/2022 was "DOCUSATE SODIUM 100MG/CAP, GIVE 1 CAP PO ONCE DAILY IF NO BM AFTER 1 DAY INCREASE DOSE BACK TO 2 CAPS DAILY." Medication bottle label was "Take 1 capsule by mouth daily. Hold for loose bowel movement." Physician's written order and medication bottle label did not match.</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 wrote on the paper the order Docusate Sodium 100mg/cap, Give 1 Cap PO Once Daily. If no BM after 1 Day Increase Dose Back to 2 Caps Daily and put on the bottle and rubber band it. Until a new bottle receive which the cur- rent order label.</p>	<p>1/13/23</p> <p>23 JAN -4 AMO:21</p> <p>STATE OF ILLINOIS DEPT. OF HEALTH STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms.</p> <p><u>FINDINGS</u> Resident #1 – Physician's order 9/28/2022 was "DOCUSATE SODIUM 100MG/CAP, GIVE 1 CAP PO ONCE DAILY IF NO BM AFTER 1 DAY INCREASE DOSE BACK TO 2 CAPS DAILY." Medication bottle label was "Take 1 capsule by mouth daily. Hold for loose bowel movement." Physician's written order and medication bottle label did not match.</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>If the alder in charge the same medication in order bottle is available. I will write the new order on the paper and then rubberband it on the bottle.</p>	<p>11/3/23</p> <p>23 JAN -4 A10:21</p> <p>STATE OF ILLINOIS DEPT. OF REG. & COMM. STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (c) Separate compartments shall be provided for each resident's medication and they shall be segregated according to external or internal use.</p> <p>FINDINGS Resident #1 – External and internal medication stored in the same container. Corrected during inspection.</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>23 JAN -4 AIO:21</p> <p>STATE OF ILLINOIS DOH-CHCA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (c) Separate compartments shall be provided for each resident's medication and they shall be segregated according to external or internal use.</p> <p><u>FINDINGS</u> Resident #1 – External and internal medication stored in the same container. Corrected during inspection.</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 will make sure to separate the External and Internal medication stored in the same container. And also I will trained my SCG/HM to do the same.</p>	<p>1/3/23</p> <p>23 JAN -4 AIO:21</p> <p>STATE OF CONNECTICUT DEPT. 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> (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 – Per medication administration record (MAR), Bicalutamide 50mg was started on 3/1/2022. There was no physician's order to start the medication. Order was not obtained until 8/9/2022.</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>23 JAN -4 AMO :21</p> <p>STATE OF HAWAII DEPT. OF HEALTH 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 – Per medication administration record (MAR), Bicalutamide 50mg was started on 3/1/2022. There was no physician's order to start the medication. Order was not obtained until 8/9/2022.</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>If the medication needs clarification I will call or email the doctors office and obtained the order. If its a telephone order i'll record in a physician order sheet.</p>	<p>1/3/23</p> <p>23 JAN -4 110:21</p> <p>STATE OF HAWAII DOH-DHCA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (h) All telephone and verbal orders for medication shall be recorded immediately on the physician's order sheet and written confirmation shall be obtained at the next physicians visit and not later than four months from the date of the verbal order for the medication.</p> <p>FINDINGS Resident #1 – Per progress notes, Benzonatate 100mg cap, 1 cap TID for 10 days (10/13/2022 to 10/23/2022) was ordered during telehealth visit. The order was not recorded in physician's order sheet.</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>23 JAN -4 AIO :21</p> <p>STATE OF HAWAII DOH-DHCA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (h) All telephone and verbal orders for medication shall be recorded immediately on the physician's order sheet and written confirmation shall be obtained at the next physicians visit and not later than four months from the date of the verbal order for the medication.</p> <p><u>FINDINGS</u> Resident #1 – Per progress notes, Benzonatate 100mg cap, 1 cap TID for 10 days (10/13/2022 to 10/23/2022) was ordered during telehealth visit. The order was not recorded in physician's order sheet.</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 will review all the documents at least once a month at the end of the month. And i will document it necessary at that time.</p>	<p>1/3/23</p> <p>23 JAN -4 AIO:21</p> <p>STATE OF CONNECTICUT DEPARTMENT OF CONSUMER PROTECTION STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p><u>FINDINGS</u> Resident #1 – Physician's notes dated 2/8/2022 stated "During the day, make sure to stand up and stretch every 2 hours safely," and notes dated 8/9/2022 stated "walk at least 5 times per day." The services provided and resident's response to the services were not documented in progress notes.</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>23 JAN -4 AMO :21</p> <p>STATE OF HAWAII DOH-ARTA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p><u>FINDINGS</u> Resident #1 – Physician's notes dated 2/8/2022 stated "During the day, make sure to stand up and stretch every 2 hours safely," and notes dated 8/9/2022 stated "walk at least 5 times per day." The services provided and resident's response to the services were not documented in progress notes.</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 will review all the documents at least once a month at the end of the month. And i will document if necessary at that time.</p>	<p>1/3/23</p> <p>23 JAN -4 AMO :22</p> <p>STATE OF HAWAII DOH-SHCA STATE LICENSING</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (h)(1) Miscellaneous records:</p> <p>A permanent general register shall be maintained to record all admissions and discharges of residents;</p> <p><u>FINDINGS</u> In Permanent Resident Register, only types of facilities were recorded in "Admitted from" field, not facility names.</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>23 JAN -4 AMO:22</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (h)(1) Miscellaneous records:</p> <p>A permanent general register shall be maintained to record all admissions and discharges of residents;</p> <p>FINDINGS In Permanent Resident Register, only types of facilities were recorded in "Admitted from" field, not facility names.</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>make sure to write the complete facility name. and review at least once a month at the end of the month.</p>	<p>1/3/23</p> <p>23 JAN -4 AMO:22</p> <p>STATE OF HAWAII</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (r) Facilities shall be maintained in accordance with provisions of state and local zoning, building, fire safety and health codes.</p> <p>FINDINGS Only No-Splash bleach and germicidal bleach were available to sanitize the dishes.</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 bought the regular bleach and its available.</p>	<p>1/3/23</p> <p>23 JAN -4 10:22</p> <p>SMITHSONIAN INSTITUTION</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (r) Facilities shall be maintained in accordance with provisions of state and local zoning, building, fire safety and health codes.</p> <p>FINDINGS Only No-Splash bleach and germicidal bleach were available to sanitize the dishes.</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 will have a back up bottle and whenever I go to shopping I would checked if regular or concentrated which is available at the store.</p>	<p>1/3/23</p> <p>STATE OF HAWAII DEPARTMENT OF COMMUNITY DEVELOPMENT JAN -4 AMO 22</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)(2) 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>Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident;</p> <p><u>FINDINGS</u> Resident #1 – Diagnoses included Hyperplasia of Prostate with Lower Urinary Tract Symptoms and Nocturia. No care plan to address these issues.</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>the case manager provided a care plan for resident #1 on 11/4/22. See attached.</p>	<p>11/4/22</p> <p>23 JAN -4 AMO:22</p> <p>STATE OF HAWAII DEPARTMENT OF HEALTH STATE LICENSING</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(2) 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>Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident;</p> <p><u>FINDINGS</u> Resident #1 – Diagnoses included Hyperplasia of Prostate with Lower Urinary Tract Symptoms and Nocturia. No care plan to address these issues.</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>I will review the care plan with the case manager at least once a month and then request to update as needed.</i></p>	<p><i>1/3/22</i></p> <p>23 JAN -4 AMO:22</p> <p>STATE OF MICHIGAN DOH-ENCA STATE LICENSING</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-88 <u>Case management qualifications and services.</u> (c)(2) 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>Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident;</p> <p><u>FINDINGS</u> Resident #2 – No care plan available. The resident is wheelchair bound and requires total assistance for ADLs.</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 resident # 2 was discharge last 11/17/22. And un able to obtained a care plan.</i></p>	<p><i>1/3/22</i></p> <p>23 JAN -4 MO 22</p> <p>STATE OF MARYLAND DEPARTMENT OF LICENSING STATE LICENSING</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)(2) 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>Develop an interim care plan for the expanded ARCH resident within forty eight hours of admission to the expanded ARCH and a care plan within seven days of admission. The care plan shall be based on a comprehensive assessment of the expanded ARCH resident's needs and shall address the medical, nursing, social, mental, behavioral, recreational, dental, emergency care, nutritional, spiritual, rehabilitative needs of the resident and any other specific need of the resident. This plan shall identify all services to be provided to the expanded ARCH resident and shall include, but not be limited to, treatment and medication orders of the expanded ARCH resident's physician or APRN, measurable goals and outcomes for the expanded ARCH resident; specific procedures for intervention or services required to meet the expanded ARCH resident's needs; and the names of persons required to perform interventions or services required by the expanded ARCH resident;</p> <p><u>FINDINGS</u> Resident #2 – No care plan available. The resident is wheelchair bound and requires total assistance for ADLs.</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>before admitting a resident I will request all required documents including care plan and I will the admission checklist.</i></p>	<p><i>1/3/23</i></p> <p>23 JAN -4 AMO :22</p> <p>STATE OF HAWAII DEPT. OF HEALTH STATE LICENSING</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)(3) 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>Review the care plan monthly, or sooner as appropriate;</p> <p><u>FINDINGS</u> Resident #1 – There was no RN case manager's notes for October 2022 visit.</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 obtained the RN case manager notes for October and place it in the binder See attached.</p>	<p>1/3/23</p> <p>23 JAN -4 110:22</p> <p>STATE OF ILLINOIS DEPT. OF HEALTH STATE LICENSING</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)(3) 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>Review the care plan monthly, or sooner as appropriate;</p> <p><u>FINDINGS</u> Resident #1 – There was no RN case manager's notes for October 2022 visit.</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>If i don't recieved a visit with- in 10 days I will contact the RN case manager and obtained the record.</i></p>	<p><i>1/3/23</i></p> <p>23 JAN -4 MO:22</p> <p>STATE OF HAWAII DH-60CA STATE LICENSING</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)(6) 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>Coordinate care giver training, hospital discharge, respite, home transfers and other services as appropriate. Facilitate, advocate and mediate for expanded ARCH residents, care givers and service providers to ensure linkages and provision of quality care for the optimal function of the expanded ARCH resident;</p> <p><u>FINDINGS</u> Resident #1 – No documentation that RN case manager trained care givers for fall precaution.</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>RN Case manager trained all care-givers for fall precaution on 11/4/22 See attached.</p>	<p>11/4/22</p> <p>23 JAN -4 AMO:22</p> <p>STATE OF ILLINOIS BOH-CHCA STATE LICENSING</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)(6) 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>Coordinate care giver training, hospital discharge, respite, home transfers and other services as appropriate. Facilitate, advocate and mediate for expanded ARCH residents, care givers and service providers to ensure linkages and provision of quality care for the optimal function of the expanded ARCH resident;</p> <p><u>FINDINGS</u> Resident #1 – No documentation that RN case manager trained care givers for fall precaution.</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>I will review the training documents with the case manager At least once-a month</i></p>	<p><i>1/3/23</i></p> <p>23 JAN -4 AM 10:22</p> <p>STATE OF ILLINOIS DOH-DRCA STATE LICENSING</p>

Licensee's/Administrator's Signature: ma/konid/

Print Name: MILAGROS RONDEL

Date: 1/3/23

STATE OF HAWAII
DOH-CIDA
STATE LICENSING

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