

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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| <b>Facility's Name:</b> Manoa View Carehome LLC                  | <b>CHAPTER 100.1</b>                        |
| <b>Address:</b><br>2625 Ferdinand Avenue, Honolulu, Hawaii 96822 | <b>Inspection Date:</b> May 5, 2023 Initial |

**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.**

08/16/16, Rev 09/09/16, 03/06/18, 04/16/18

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date                         |
|-------------------------------------|--|---|---|
| <input checked="" type="checkbox"/> | <p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u><br/>(a)<br/>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><b><u>FINDINGS</u></b><br/>Substitute Care Giver (SCG) #1, #3, #4 – No current annual physical exam.</p> <p>Please submit a copy with your plan of correction (POC).</p> | <p>PART 1</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I now have annual physical Exam for SCG #1, #3 #4 and placed it on my carehome binder. copy attached</p> | <p>5/18/23</p> <p>23 MAY 26 PM 2:29</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                       |
|-------------------------------------|---|---|---------------------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u><br/> (a)<br/> 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><b><u>FINDINGS</u></b><br/> Substitute Care Giver (SCG) #1, #3, #4 – No current annual physical exam.</p> <p>Please submit a copy with your plan of correction (POC).</p> | <p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>To prevent this from happening again. I will check monthly to ensure all the annual physical exam is current.</p> <p>Remind all my care give to up up-date physical exam, two months inspection</p> | <p>5/18/23</p> <p>23 MAY 26 13:09</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                        |
|-------------------------------------|---|---|--|
| <input checked="" type="checkbox"/> | <p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u><br/>(b)<br/>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><b><u>FINDINGS</u></b><br/>SCG #4 – No initial tuberculosis clearance.</p> <p>Please submit a copy with your POC.</p> | <p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I have provided initial Tuberculosis clearance for SCG #4 and put in on my care home binder.</p> <p>copy attached</p> | <p>5/12/23</p> <p>23 MAY 26 P 3:08</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date                       |
|-------------------------------------|--|---|---------------------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u><br/>(b)<br/>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><br/>SCG #4 – No initial tuberculosis clearance.</p> <p>Please submit a copy with your 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>In the future to prevent this from happening, I will check at the beginning of each month to ensure I have all initial TB clearance being updated.</p> <p>Remind all caregiver 2 months before inspection.</p> | <p>5/12/23</p> <p>23 MAY 26 P3:08</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date                      |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u><br/>(e)(3)<br/>The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p><b><u>FINDINGS</u></b><br/>SCG #2 – No first aid certification.</p> <p>Please submit a copy with your POC.</p> | <p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I have obtained the first aid certification for my SCG #2 and filed it on my carehome binder, also I have provided a copy and attached it.</p> | <p>5/6/23</p> <p>23 MAY 26 P3:08</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date                      |
|-------------------------------------|--|--|--------------------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u><br/>(e)(3)<br/>The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p><b><u>FINDINGS</u></b><br/>SCG #2 – No first aid certification.</p> <p>Please submit a copy with your POC.</p> | <p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future, I will keep a spread sheet of caregiver requirements and write down the expiration dates and post it on my fridge as a reminder.</p> <p>Remind all caregiver to up-date certification two months before inspection.</p> | <p>5/6/23</p> <p>23 MAY 26 P3:08</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                        |
|-------------------------------------|---|---|--|
| <input checked="" type="checkbox"/> | <p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u><br/>(e)(4)<br/>The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><b><u>FINDINGS</u></b><br/>No record that Primary Care Giver (PCG) trained SCG to make prescribed medication available to residents.</p> | <p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I have provided the substitute caregiver documents to make prescribed available to residents and now have caregiver training documents being recorded</p> | <p>5/8/23</p> <p>23 MAY 26 PM 3:08</p> |



|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                              |
|-------------------------------------|---|---|--|
| <input checked="" type="checkbox"/> | <p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u><br/>(e)(4)<br/>The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><b><u>FINDINGS</u></b><br/>No record that Primary Care Giver (PCG) trained SCG to make prescribed medication available to residents.</p> | <p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>I have obtained and trained SCG to make prescribed medication available to residents and place it into my carehome binder.</i></p> <p><i>I will use caregiver checklist.</i></p> | <p><i>5/6/23</i></p> <p>23 MAY 26 P 3:08</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                        |
|-------------------------------------|---|---|--|
| <input checked="" type="checkbox"/> | <p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u><br/>(f)(1)<br/>The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:</p> <p>Be currently certified in cardiopulmonary resuscitation;</p> <p><b><u>FINDINGS</u></b><br/>SCG #2 – No cardiopulmonary resuscitation certification.</p> <p>Please submit a copy with your POC.</p> | <p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I have obtained a copy of cardiopulmonary resuscitation certification and filed into care home binder.</p> <p>See copy attached</p> | <p>5/6/23</p> <p>23 MAY 26 PM 3:08</p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u><br/>(f)(1)<br/>The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:</p> <p>Be currently certified in cardiopulmonary resuscitation;</p> <p><u>FINDINGS</u><br/>SCG #2 – No cardiopulmonary resuscitation certification.</p> <p>Please submit a copy with your POC.</p> | <p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future to prevent from happening again, I will check every week to make sure all CPR or cardiopulmonary resuscitation certification was up to date for each substitute caregiver and PCG.</p> <p>Remind caregiver two months before inspection.</p> | <p>5/6/23</p> <p>23 MAY 26 P3:08</p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-10 <u>Admission policies.</u> (g)<br/>An inventory of all personal items brought into the Type I ARCH by the resident shall be maintained.</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – Inventory of all personal items not recorded at admission.</p> | <p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I have provided and recorded the inventory of all personal items for resident #1 and place it to resident chart.</p> | <p>5/6/23</p> <p>23 MAY 26 P3:07</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date                      |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-10 <u>Admission policies.</u> (g)<br/>An inventory of all personal items brought into the Type I ARCH by the resident shall be maintained.</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – Inventory of all personal items not recorded at admission.</p> | <p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>Upon admission I will check and complete the inventory of all personal items and recorded correctly and placed it to the resident binder. I will use admission checklist.</p> | <p>5/6/23</p> <p>23 MAY 26 P3:07</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date   |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-12 <u>Emergency care of residents and disaster preparedness.</u> (c)<br/> The licensee shall conduct regular quarterly rehearsals of emergency evacuation plans for staff and residents to follow in case of fire, explosion, or other civil emergency occurring in or within the environs of the facility.</p> <p><b><u>FINDINGS</u></b><br/> Resident #1 – No record that resident #1 received orientation for emergency procedures.</p> | <p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I have provided and recorded the emergency procedure to my resident #1 and filed it into the resident chart.</p> | <p>5/6/23</p> <p>23 MAY 26 P3:07</p> <p>STATE OF IDAHO<br/> DEPARTMENT OF HEALTH<br/> STATE LICENSING</p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-12 <u>Emergency care of residents and disaster preparedness.</u> (c)<br/> The licensee shall conduct regular quarterly rehearsals of emergency evacuation plans for staff and residents to follow in case of fire, explosion, or other civil emergency occurring in or within the environs of the facility.</p> <p><b><u>FINDINGS</u></b><br/> Resident #1 – No record that resident #1 received orientation for emergency procedures.</p> | <p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future to prevent this again from happening I will immediately orient resident for emergency procedure and document it, also I will review the record once a month</p> | <p>5/6/23</p> <p>23 MAY 26 P3:07</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date        |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-13 <u>Nutrition</u>. (e)<br/>Substitutes offered to residents who refuse food served shall be of similar nutritive value and documented.</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – Per Primary Care Giver (PCG), snack (ice cream, Jell-O pudding, and water) was given at 9:30am. Snack menu was ½ bell pepper, 1 cup of carrots sticks, and 4 tbsp of guacamole.</p> <p>PCG stated that breakfast was given at 6:30am, oatmeal, bread, banana, coffee, and hot tea. The menu for breakfast was 1 cup of steel-cut oats, 1 tbsp of hemp seeds, 1 tbsp of flax seeds, 2 tbsp of dried cherries, and 1 cup of water. No menu substitution recorded.</p> | <p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> <p>STAFF REVIEWED<br/>DATE: 5/23/23<br/>BY: [Signature]</p> | <p>23 MAY 26 P3:07</p> |



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| <input checked="" type="checkbox"/> | <p>§11-100.1-13 <u>Nutrition.</u> (e)<br/>Substitutes offered to residents who refuse food served shall be of similar nutritive value and documented.</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – Per Primary Care Giver (PCG), snack (ice cream, Jell-O pudding, and water) was given at 9:30am. Snack menu was ½ bell pepper, 1 cup of carrots sticks, and 4 tbsp of guacamole.</p> <p>PCG stated that breakfast was given at 6:30am, oatmeal, bread, banana, coffee, and hot tea. The menu for breakfast was 1 cup of steel-cut oats, 1 tbsp of hemp seeds, 1 tbsp of flax seeds, 2 tbsp of dried cherries, and 1 cup of water. No menu substitution recorded.</p> | <p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future to prevent from happening all caregivers were informed and trained to record the alternate meals/ substitute menu when it<sup>is</sup> being served also. I will provide the substitute menu sheet and make sure all the meal and snacks was recorded in to the menu substitute.</p> | <p>5/5/23</p> <p>23 MAY 26 P 3:07</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date         |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-14 <u>Food sanitation</u>, (f)<br/>Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.</p> <p><b><u>FINDINGS</u></b><br/>Bleach container was stored in unlocked under the sink cabinet in the kitchen. Corrected during inspection.</p> | <p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> <p>STATE OF NEW YORK<br/>DEPARTMENT OF HEALTH<br/>OFFICE OF INSPECTION</p> | <p>23 MAY 26 P 3:07</p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-14 <u>Food sanitation.</u> (f)<br/>Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies.</p> <p><u>FINDINGS</u><br/>Bleach container was stored in unlocked under the sink cabinet in the kitchen. 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>To prevent this from occurring in the future myself and substitute will always check to make sure bleach container was stored and locked everytime we use it.</p> <p>I provided training all caregiver</p> | <p>5/5/23</p> <p>23 MAY 26 PM 3:07</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications.</u> (b)<br/>           Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.</p> <p><b><u>FINDINGS</u></b><br/>           Calmoceptine ointment was left unsecure inside the drawer of the dresser placed by residents' bedrooms.<br/>           Lidocaine patches were left unsecure in resident's bedroom #3.<br/>           The medications were secured during inspection.</p> | <p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> |                 |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications.</u> (b)<br/>           Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container.</p> <p><u>FINDINGS</u><br/>           Calmoceptine ointment was left unsecure inside the drawer of the dresser placed by residents' bedrooms.<br/>           Lidocaine patches were left unsecure in resident's bedroom #3.<br/>           The medications were secured during inspection.</p> | <p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>To prevent this from happening again I will everyday check and stored all medication including ointment and patches and place it into the cabinet being locked is secured</p> <p>I will check environment everyday in the morning when I clean.</p> | <p>5/5/23</p> <p>23 MAY 26 P3:07</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date         |
|-------------------------------------|---|---|-------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications.</u> (c)<br/>           Separate compartments shall be provided for each resident's medication and they shall be segregated according to external or internal use.</p> <p><b><u>FINDINGS</u></b><br/>           Resident #1 – External and internal medication were stored in the same container. Corrected during inspection.</p> | <p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> | <p>23 MAY 26 P 3:07</p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications</u>. (c)<br/>           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><br/>           Resident #1 – External and internal medication were 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>To prevent this from happening again in the future I will place external and internal medication, separated from each other in separate containers or plastic ziplock bags. Myself and substitutes will check daily the medication to ensure that the external and internal medications are remained separated</p> | <p>5/5/23</p> <p>23 MAY 26 P 3:07</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                        |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications</u>. (e)<br/>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><br/>Resident #1 – Physician's order dated 4/30/2023 included Ensure Plus, which was not available at home.</p> | <p>PART 1</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I have provided ensure plus for my Resident #1 and place it into the fridge.</p> | <p>5/17/23</p> <p>23 MAY 26 P 3:07</p> |



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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications.</u> (e)<br/>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><br/>Resident #1 – Physician's order dated 4/30/2023 included Ensure Plus, which was not available at home.</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>In the future I will check everyday to make sure have ensure plus available at all times for the resident being prescribed by the physician.</p> <p>If I need refill call the Dr. with in 24 hrs.</p> | <p>5/17/23</p> <p>23 MAY 26 P 3:07</p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications</u>. (e)<br/>All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – Physician's order dated 4/30/2023 included Ensure Plus. Dosage, route, and frequency not provided.</p> | <p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I now have ensure plus dosage, route and frequency and place it into the resident binder</p> <p>Physician (obtain) order. was obtain.</p> | <p>5/17/23</p> <p>23 MAY 26 P 3:07</p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications.</u> (e)<br/>All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – Physician's order dated 4/30/2023 included Ensure Plus. Dosage, route, and frequency not provided.</p> | <p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>Once i recieved a current physician order for a resident from physician, I will check each order and make sure i have dosage, route, frequency and ensure plus being recorded</p> <p>i will review every two week, if i hted erimfacation, i will contact the Dr whuch in 24hrs.</p> | <p>5/17/23</p> <p>23 MAY 26 P 3:06</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date   |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications.</u> (e)<br/>All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – Physician’s order dated 4/30/2023 was “Lidocaine 4% Ptch, Apply 1 patch externally once per day as needed.” Indication for as needed use not provided.</p> | <p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I have obtain and documented as need for Lidocaine 4% patch apply 1 patch externally once per day as and place it in to my resident binder</p> <p>physician order obtain, as needed for pain.</p> | <p>5/17/23.</p> <p style="text-align: right;">23 MAY 26 PM 3:06</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date                       |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications</u>. (e)<br/>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><br/>Resident #1 – Physician’s order dated 4/30/2023 was “Lidocaine 4% Pch, Apply 1 patch externally once per day as needed.” Indication for as needed use not provided.</p> | <p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN’T HAPPEN AGAIN?</b></p> <p>The moment i recieved the physician order. I will accurately write the order including as need indication on the MAR. I will check the MAR at the beginning each month to ensure that its accurated with the current physician order</p> <p>Re I will review Dr order every two week and if i need <del>vet</del> crapocation I will contact the Dr. which in 24hrs.</p> | <p>5/17/23</p> <p>23 MAY 26 P3:06</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date         |
|-------------------------------------|--|---|-------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications</u>. (e)<br/>All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – Tramadol 50mg was dispensed QTY 12 on 4/30/2023. There were eight (8) tablets left in the container. Unable to verify when the medication was given, as medication administration record (MAR) was not initialed. PCG noted “8A” and “2P” from 5/1/2023 to 5/5/2023.</p> | <p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> | <p>23 MAY 26 P 3:06</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date                       |
|-------------------------------------|--|--|---------------------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications</u>. (e)<br/>All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – Tramadol 50mg was dispensed QTY 12 on 4/30/2023. There were eight (8) tablets left in the container. Unable to verify when the medication was given, as medication administration record (MAR) was not initialed. PCG noted “8A” and “2P” from 5/1/2023 to 5/5/2023.</p> | <p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>To prevent thing happening. I will check and reviewed everyday each medication to ensure that the medication was given and initialed accurately.</p> | <p>5/6/23</p> <p>23 MAY 26 P 3:06</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date                        |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications.</u> (m)<br/>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><br/>Resident #1 – Physician ordered Ensure Plus on 4/30/2023. Not listed 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 have obtained and listed in the ensureplus into the MAR and place it into the residents chart.</p> | <p>5/17/23</p> <p>23 MAY 26 P 3:06</p> |



|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date                       |
|-------------------------------------|--|--|---------------------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications</u>. (m)<br/>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><br/>Resident #1 – Physician ordered Ensure Plus on 4/30/2023. Not listed 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>In the future to prevent this from happening, everyday I will check each prescription ordered by physician to ensure I have all listed in MAR. also I will review the record once a month</p> | <p>5/17/23</p> <p>23 MAY 26 P3:06</p> |

|   | RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date         |
|---|--|--|-------------------------|
| ☒ | <p>§11-100.1-15 <u>Medications.</u> (m)<br/>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><b><u>FINDINGS</u></b><br/>Resident #1 – In MAR, Tramadol 50mg administration time was recorded as “8A” and “2P” from 5/1/2023 to 5/5/2023, instead of care giver’s initial.</p> | <p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> <p>STATE OF CONNECTICUT<br/>DEPT. OF SOCIAL SERVICES<br/>STATELKS:RSMG</p> | <p>23 MAY 26 P 3:06</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date                      |
|-------------------------------------|---|--|--------------------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-15 Medications. (m)<br/>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><b><u>FINDINGS</u></b><br/>Resident #1 – In MAR, Tramadol 50mg administration time was recorded as “8A” and “2P” from 5/1/2023 to 5/5/2023, instead of care giver’s initial.</p> | <p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future to prevent this from occurring everyday, I will review to make sure, I initialed correctly column.</p> | <p>5/6/23</p> <p>23 MAY 26 P3:06</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date  |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-16 <u>Personal care services.</u> (h)<br/>A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed.</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – No individualized plan of care and activities schedule. Physician's notes dated 4/30/2023 stated the resident is allowed only "toe touch weight bearing."</p> | <p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I have obtained and provided individualized plan of care and activities schedule put it on my resident chart. also i posted into my fridge</p> <p>Resident improved. physician order no restriction was received.</p> | <p>5/6/23</p> <p>23 MAY 26 P 3:06</p> <p>STATE OF OHIO<br/>DEPARTMENT OF<br/>STATE LICENSING</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date                       |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-16 <u>Personal care services.</u> (h)<br/>A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed.</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – No individualized plan of care and activities schedule. Physician's notes dated 4/30/2023 stated the resident is allowed only "toe touch weight bearing."</p> | <p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>upon admission, I will check and complete the checklist and have the individualized plan of care and activities schedule being provided and have the family/guardian sign it and place it into the resident binder,</p> <p>I will use admission check list to complete assessment and evaluate resident condition.</p> | <p>5/6/23</p> <p>23 MAY 26 P 3:06</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date  |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (a)(1)<br/> 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><b><u>FINDINGS</u></b><br/> Resident #1 – Admission assessment was completed partially.</p> | <p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> | <p>STATE OF NEW YORK<br/> OFFICE OF THE ATTORNEY GENERAL<br/> JUL 26 2013 10:06 AM</p> |

23 JUL 26 P 3:06

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date                       |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (a)(1)<br/>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><br/>Resident #1 – Admission assessment was completed partially.</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>In the future to prevent this happening, I will check everyday to ensure admission assessment was completed immediately</p> <p>I will used admission check list to complete admission assessment.</p> | <p>5/6/23</p> <p>23 MAY 26 P 3:06</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                       |
|-------------------------------------|---|---|---------------------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (a)(4)<br/>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>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;</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – "Resident Annual Physician Examination Record" form dated 4/30/2023 stated "See H &amp; P." But no information was included for the physical exam in the available documents.</p> | <p>PART 1</p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I have obtained annual physical Exam Record for resident #1 and place it into the resident binder.</p> | <p>5/26/23</p> <p>23 MAY 26 P3:06</p> |



|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date                       |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (a)(4)<br/>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>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;</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – "Resident Annual Physician Examination Record" form dated 4/30/2023 stated "See H &amp; P." But no information was included for the physical exam in the available documents.</p> | <p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future to prevent this from happening every day, I will checked each document to ensure all the papers checklist was recorded into available document.</p> <p>If clarify if needed, I will contact the Physician <sup>which</sup> in 24 hrs -</p> | <p>5/26/23</p> <p>23 MAY 26 P3:06</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date         |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (a)(7)<br/> 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>Height and weight measurements taken;</p> <p><u>FINDINGS</u><br/> Resident #1 – No record that weight and height were taken at admission.</p> | <p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> | <p>23 MAY 26 P 3:06</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date                       |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (a)(7)<br/>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>Height and weight measurements taken;</p> <p><b>FINDINGS</b><br/>Resident #1 – No record that weight and height were taken at admission.</p> | <p>PART 2</p> <p>FUTURE PLAN</p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>In the future upon admission all Resident weight and height was immediately recorded and place it into carehome binder</p> <p>I will used admission assessment to obtain or required information.</p> | <p>5/6/23</p> <p>23 MAY 26 P 3:05</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date         |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (b)(3)<br/>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><b><u>FINDINGS</u></b><br/>Resident #1 – No progress notes.</p> | <p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> <p>STATE OF CONNECTICUT<br/>DEPARTMENT OF SOCIAL SERVICES<br/>SOUTH BRITAIN, CT 06053</p> | <p>23 MAY 26 P 3:05</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                       |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (b)(3)<br/>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><b><u>FINDINGS</u></b><br/>Resident #1 – No progress notes.</p> | <p><b>PART 2</b></p> <p><b>FUTURE PLAN</b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>To prevent this from happening again<br/> I will immediately document and recorded the progress note for all residents and make sure I have all the information being added and signed it.</p> <p>I will review and document and the end of the month.</p> | <p>5/5/23</p> <p>23 MAY 26 P 3:05</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date         |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (f)(2)<br/>General rules regarding records:</p> <p>Symbols and abbreviations may be used in recording entries only if a legend is provided to explain them;</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – No legend for care giver's initial in MAR.<br/>Corrected during inspection.</p> | <p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> | <p>23 MAY 26 P 3:05</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                       |
|-------------------------------------|---|---|---------------------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (f)(2)<br/>General rules regarding records:</p> <p>Symbols and abbreviations may be used in recording entries only if a legend is provided to explain them;</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – No legend for care giver's initial in MAR.<br/>Corrected during inspection.</p> | <p><b>PART 2</b></p> <p><b>FUTURE PLAN</b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>in the future to prevent this happening again, I have checked everyday and make sure I have initialed the MAR from the date of admission.</p> <p>I will make sure to write legend for care giver when I paper next months MAR. also I will review monthly.</p> | <p>5/5/23</p> <p>23 MAY 26 P 3:05</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date                       |
|-------------------------------------|--|---|---------------------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (f)(4)<br/>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><b><u>FINDINGS</u></b><br/>"Height and Monthly Weight Record" form not documented.</p> | <p><b>PART 1</b></p> <p><b>DID YOU CORRECT THE DEFICIENCY?</b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I now have height weight being recorded and place it on my binder.</p> | <p>5/6/23</p> <p>23 NOV 26 P 3:05</p> |



|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date                       |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (f)(4)<br/>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><b><u>FINDINGS</u></b><br/>"Height and Monthly Weight Record" form not documented.</p> | <p><b>PART 2</b></p> <p><b>FUTURE PLAN</b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>upon admission to prevent this from happening again all residents height and monthly weight was immediately recorded. Also I will review monthly.</p> <p>I will check all resident weight every first Monday of the months.</p> | <p>5/6/23</p> <p>23 MAY 26 P 3:05</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date                       |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (f)(4)<br/>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><b><u>FINDINGS</u></b><br/>Resident #1 – No Emergency Information Sheet available.</p> | <p><b>PART 1</b></p> <p><b>DID YOU CORRECT THE DEFICIENCY?</b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I have obtained and recorded all emergency information residents #1 and now have available Emergency Information sheet all the time and inserted into the resident chart.</p> | <p>5/6/23</p> <p>23 MAY 26 P 3:05</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date                       |
|-------------------------------------|---|--|---------------------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (f)(4)<br/>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><b>FINDINGS</b><br/>Resident #1 – No Emergency Information Sheet available.</p> | <p><b>PART 2</b></p> <p><b>FUTURE PLAN</b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future to prevent this again from happening, I will update the residents Emergency information sheets yearly or immediately, when there is a change in there emergency information. I will put a reminder a month before the year expiration of the information sheet on a calendar that it needs to be updated. Also I will review the record once a month.</p> | <p>5/6/23</p> <p>23 MAY 26 P 3:05</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date                       |
|-------------------------------------|---|--|---------------------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (h)(1)<br/>Miscellaneous records:</p> <p>A permanent general register shall be maintained to record all admissions and discharges of residents;</p> <p><b><u>FINDINGS</u></b><br/>Resident Register not recorded. One (1) current resident admitted on 4/30/2023.</p> | <p><b>PART 1</b></p> <p><b>DID YOU CORRECT THE DEFICIENCY?</b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I now have information being recorded in resident register for resident admitted on 4/30/23 and place it into carehome binder</p> | <p>5/6/23</p> <p>23 MAY 26 P 3:05</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                       |
|-------------------------------------|---|---|---------------------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (h)(1)<br/>Miscellaneous records:</p> <p>A permanent general register shall be maintained to record all admissions and discharges of residents;</p> <p><b><u>FINDINGS</u></b><br/>Resident Register not recorded. One (1) current resident admitted on 4/30/2023.</p> | <p><b>PART 2</b></p> <p><b>FUTURE PLAN</b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future, I will check every day to ensure all resident register was documented and filed into my Care Home binder.</p> <p>I will used admission check list to remind myself to complete resident register.</p> | <p>5/6/23</p> <p>23 MAY 26 P 3:05</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date                        |
|-------------------------------------|--|--|--|
| <input checked="" type="checkbox"/> | <p>§11-100.1-20 <u>Resident health care standards.</u> (a)<br/>The primary and substitute care giver shall provide health care within the realm of the primary or substitute care giver's capabilities for the resident as prescribed by a physician or APRN.</p> <p><b><u>FINDINGS</u></b><br/>Resident #1 – Physician noted “toe touch weight bearing” on 4/30/2023. Resident’s activity limitation was not clarified.</p> | <p><b>PART 1</b></p> <p><b>DID YOU CORRECT THE DEFICIENCY?</b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I have contacted PCP and clarify residents activity limitation for resident #1 and have Doctors (ordered) ordered for PT/OT and place it into the resident binder.</p> <p>Physician ordered no restriction on activities.</p> | <p>5/26/23</p> <p>23 MAY 26 P 3:05</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date   |
|-------------------------------------|--|--|---|
| <input checked="" type="checkbox"/> | <p>§11-100.1-20 Resident health care standards. (a)<br/>The primary and substitute care giver shall provide health care within the realm of the primary or substitute care giver's capabilities for the resident as prescribed by a physician or APRN.</p> <p><b>FINDINGS</b><br/>Resident #1 – Physician noted “toe touch weight bearing” on 4/30/2023. Resident’s activity limitation was not clarified.</p> | <p><b>PART 2</b></p> <p><b>FUTURE PLAN</b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>To prevent this from happening again in the future, I have checked and clarify all the physicians note to ensure all residents activity with or without limitation was met.</p> <p>I will do admission assessment, if clarification if needed our contact the Dr which in 24 hrs.</p> | <p>5/26/23</p> <p>STATE OF CONNECTICUT<br/>DEPT. OF SOCIAL SERVICES<br/>MAY 26 2023<br/>P3:05</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                        |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-20 <u>Resident health care standards.</u> (d)<br/>When the resident has experienced a significant change in mental or physical well-being, a prompt report shall be made and provided to the resident's physician or APRN, by the primary or substitute caregiver. Any change in physician or APRN orders shall be promptly carried out.</p> <p><b>FINDINGS</b><br/>Resident #1 – Resident was discharged from hospital on 4/30/2023. There was no record that follow up visit with a physician was scheduled or made since discharge.</p> | <p><b>PART 1</b></p> <p><b>DID YOU CORRECT THE DEFICIENCY?</b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I have contacted PCP for follow-up visit and was scheduled 6/15/23 and put it on my calendar as a reminder</p> | <p>5/6/23</p> <p>23 MAY 26 PM 3:05</p> |



|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                        |
|-------------------------------------|---|---|--|
| <input checked="" type="checkbox"/> | <p>§11-100.1-20 <u>Resident health care standards.</u> (d)<br/>When the resident has experienced a significant change in mental or physical well-being, a prompt report shall be made and provided to the resident's physician or APRN, by the primary or substitute caregiver. Any change in physician or APRN orders shall be promptly carried out.</p> <p><b>FINDINGS</b><br/>Resident #1 – Resident was discharged from hospital on 4/30/2023. There was no record that follow up visit with a physician was scheduled or made since discharge.</p> | <p><b>PART 2</b></p> <p><b>FUTURE PLAN</b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future to prevent this from happening, I will immediately call PCP within 3 days upon admission to schedule follow-up visit and posted into calendar and have checked everyday.</p> | <p>5/6/23</p> <p>23 MAY 25 PM 3:05</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date  |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(G)<br/>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><b><u>FINDINGS</u></b><br/>No record that smoke detectors were tested.</p> | <p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> | <p>23 MAY 26 PM 3:05</p> <p>SEARCHED INDEXED<br/>SERIALIZED FILED<br/>MAY 26 2023<br/>FBI - NEW YORK</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date                      |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(G)<br/>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><b>FINDINGS</b><br/>No record that smoke detectors were tested.</p> | <p><b>PART 2</b></p> <p><b>FUTURE PLAN</b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future myself and all substitute caregiver will checked all the smoke detector to make sure it's all functioning, also I will tested every month and sign or initiated<br/>8th</p> | <p>5/6/23</p> <p>23 MAY 26 P3:04</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date  |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-23 <u>Physical environment.</u> (h)(3)<br/>The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p>All Type I ARCHs shall comply with applicable state laws and rules relating to sanitation, health, infection control and environmental safety;</p> <p><b>FINDINGS</b><br/>Two bags of laundry to be washed were stored in a residents' shower room. PCG removed the bags during inspection.</p> | <p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> | <p>23 MAY 26 P 3:04</p> <p>STATE OF NEW YORK<br/>DEPT. OF SOCIAL SERVICES<br/>STREET LIAISON</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION   | Completion Date                       |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-23 <u>Physical environment.</u> (h)(3)<br/>The Type I ARCH shall maintain the entire facility and equipment in a safe and comfortable manner to minimize hazards to residents and care givers.</p> <p>All Type I ARCHs shall comply with applicable state laws and rules relating to sanitation, health, infection control and environmental safety;</p> <p><b><u>FINDINGS</u></b><br/>Two bags of laundry to be washed were stored in a residents' shower room. PCG removed the bags during inspection.</p> | <p><b>PART 2</b></p> <p><b>FUTURE PLAN</b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>TO prevent this from happening every, I will checked all laundry to make sure its stored and wash it immediately.</p> <p>laundry to be wash in stored downstairs.</p> <p>STATE OF CONNECTICUT<br/>DEPT. OF SOCIAL SERVICES<br/>STATE TRAINING</p> | <p>5/6/23</p> <p>23 MAY 26 P 3:04</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date  |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-23 <u>Physical environment.</u> (o)(3)(B)<br/>Bedrooms:</p> <p>Bedroom furnishings:</p> <p>Each bed shall be supplied with a comfortable mattress cover, a pillow, pliable plastic pillow protector, pillow case, and an upper and lower sheet. A sheet blanket may be substituted for the top sheet when requested by the resident;</p> <p><b>FINDINGS</b><br/>Resident #1 – Bed mattress was covered with a plastic cover and bed sheet. Waterproof incontinence pad (36x39 inches) was directly placed under the resident. Resident's bed was not supplied with a comfortable mattress padding.</p> | <p><b>PART 1</b></p> <p><b>DID YOU CORRECT THE DEFICIENCY?</b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>I have provided water proof bed sheet and comfortable mattress padding for resident #1 and now is properly placed into the resident bed.</p> | <p>5/6/23</p> <p>23 MAY 26 P3:04</p> <p>STATE OF CONNECTICUT<br/>DEPT. OF SOCIAL SERVICES<br/>STAFF TRAINING</p> |

|                                     | RULES (CRITERIA)  | PLAN OF CORRECTION  | Completion Date                       |
|-------------------------------------|---|---|---------------------------------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-23 <u>Physical environment.</u> (o)(3)(B)<br/>Bedrooms:</p> <p>Bedroom furnishings:</p> <p>Each bed shall be supplied with a comfortable mattress cover, a pillow, pliable plastic pillow protector, pillow case, and an upper and lower sheet. A sheet blanket may be substituted for the top sheet when requested by the resident;</p> <p><b>FINDINGS</b><br/>Resident #1 – Bed mattress was covered with a plastic cover and bed sheet. Waterproof incontinence pad (36x39 inches) was directly placed under the resident. Resident's bed was not supplied with a comfortable mattress padding.</p> | <p>PART 2</p> <p>FUTURE PLAN</p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening all residents mattress should covered with waterproof bed sheet and with comfortable mattress padding</p> <p>I bought 4 more matters padding</p> | <p>5/6/23</p> <p>23 MAY 26 P 3:04</p> |

|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION  | Completion Date  |
|-------------------------------------|--|---|--|
| <input checked="" type="checkbox"/> | <p>§11-100.1-23 <u>Physical environment.</u> (p)(5)<br/>Miscellaneous:</p> <p>Signaling devices approved by the department shall be provided for resident's use at the bedside, in bathrooms, toilet rooms, and other areas where residents may be left alone. In Type I ARCHs where the primary care giver and residents do not reside on the same level or when other signaling mechanisms are deemed inadequate, there shall be an electronic signaling system.</p> <p><b>FINDINGS</b><br/>The signaling devices in residents' rooms were not working because the central wireless receiver ringer was not plugged in. The PCG plugged in the central wireless receiver ringer during inspection and all signaling devices resumed working.</p> | <p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p> | <p>23 MAY 26 P 3:04</p> <p>STATE OF NEW YORK<br/>DEPARTMENT OF<br/>CORRECTIONS</p> |



|                                     | RULES (CRITERIA)   | PLAN OF CORRECTION   | Completion Date                      |
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| <input checked="" type="checkbox"/> | <p>§11-100.1-23 <u>Physical environment.</u> (p)(5)<br/>Miscellaneous:</p> <p>Signaling devices approved by the department shall be provided for resident's use at the bedside, in bathrooms, toilet rooms, and other areas where residents may be left alone. In Type I ARCHs where the primary care giver and residents do not reside on the same level or when other signaling mechanisms are deemed inadequate, there shall be an electronic signaling system.</p> <p><b>FINDINGS</b><br/>The signaling devices in residents' rooms were not working because the central wireless receiver ringer was not plugged in. The PCG plugged in the central wireless receiver ringer during inspection and all signaling devices resumed working.</p> | <p>PART 2</p> <p>FUTURE PLAN</p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this happening again, I will check every day to make sure all the signalling device is all working good.</p> <p>I train all my caregiver to keep the device on all the time. check daily.</p> | <p>5/5/23</p> <p>23 MAY 26 P3:04</p> |

Licensee's/Administrator's Signature: Mari'loza

Print Name: Mari'loza R. Mendoza

Date: May 26 2023

Aug 8, 2023

23 AUG -8 AM 1:19  
STATE OF HAWAII  
BOH-CHCA  
STATE LICENSING

STATE OF HAWAII  
BOH-CHCA  
STATE LICENSING

23 MAY 26 PM 3:04