Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Aumoa Care Home LLC	**CHAPTER 100.1**
Address: **98-562 Kaimu Loop, Aiea, Hawaii 96701**	**Inspection Date: September 6, 2023 Annual**

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-3 Licensing. (b)(1)(I) Application. In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application: Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law; **FINDINGS** Substitute Care Giver (SCG) #1, #2 and #3 – Two (2) consecutive years of Fieldprint background checks not available.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Substitute Care Giver (SCG) #1 completed fieldprint background check on 10/11/23. SCG #2 completed fieldprint background check on 10/23/23 and SCG #3 competed Fieldprint background check 11/27/23.	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-3 Licensing. (b)(1)(I) Application. In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application: Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law; **FINDINGS** Substitute Care Giver (SCG) #1, #2 and #3 – Two (2) consecutive years of Fieldprint background checks not available.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Substitute Care Giver (SCG) #1, #2 and #3 Fieldprint background checks were completed and will complete in 2024. Second year Fieldprint background check will be completed on or before November of 2025 in compliance with the 2 consecutive year then every 2 years there after. All SCG were educated on the Fieldprint background checks completion for 2 consecutive years and every 2 years thereafter. PCG completed an audit tool which shows for each month of the year 2025, which employee is due for Fieldprint background check completion. Filedprint back ground checks audit toll will be audited every 6 months.	01/06/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. **FINDINGS** Household Member (HM) #1, and SCG #2, #3, #5 – No annual physical exam.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Household Member (HM) #1 annual physical was completed on 12/27/22. SCG #2 annual Physical Exam was completed on 9/13/23. SCG #3 has resigned. SCG #5 annual Physical Exam was completed on 12/4/23.	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. **FINDINGS** Household Member (HM) #1, and SCG #2, #3, #5 – No annual physical exam.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Household Member (HM) #1 and SCG #2, #3, #5 annual physical exam were completed. All SCG educated on the annual physical exam completion and submission to the Primary Care Giver (PCG). PCG completed an audit tool which shows for each month, which employee/HM whose annual physical exam is due. Audit tool will be completed every 6 months.	01/06/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** HM #1 and SCG #4 – No annual tuberculosis (TB) clearance. Last TB clearance available for SCG #4 from August 2022.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** HM #1 Annual TB clearance on 12/27/22 and SCG #4 annual tuberculosis (TB) clearance completed completed on 8/9/2023.	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** HM #1 and SCG #4 – No annual tuberculosis (TB) clearance. Last TB clearance available for SCG #4 from August 2022.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** HM #1 and SCG #4 Annual TB clearance completed. All SCG educated on the completion of the annual TB clearance and submission to the PCG. PCG completed an audit tool which sshows for each month, which employee whose annual TB clearance is due. Audit will be completed every 6 months.	01/06/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; **FINDINGS** PCG – No current first aid certification.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** PCG first aid certification completed on 10/28/2023.	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; **FINDINGS** PCG – No current first aid certification.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** PCG completed the first aid certification. All employees/SCG were educated by PCG on completion of the first aid certification. PCG completed an audit tool which shows for each month, which employee is due for first aid certification completion. Audit will be completed every 6 months.	01/06/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. **FINDINGS** SCG #3 – No training by the PCG to make prescribed medications available and properly record such action.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** SCG #3 received training regarding the prescription medication to be available for medication administration on 11/27/2023.	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. **FINDINGS** SCG #3 – No training by the PCG to make prescribed medications available and properly record such action.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** PCG completed SCG #3 education regarding prescribed medication for all resident to be available and completion of appropriate documentation. All SCG were educated regarding prescribed medication for all resident to be available and completion of appropriate documentation. PCG completed an audit which shows education provided for each SCG completed. The audit tool will be completed for each new employee hired for Aumoa Care Home.	09/17/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit. **FINDINGS** Resident #3 – No documented annual diet order available.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Resident# 3 diet order on 7/20/23 was clarified and reviewed by the PCP and received on 11/20/23. All resident's diet orders were audited and all orders are signed by PCP as appropriate for 2023 review. All SCG were educated by the PCG on the annual diet orders for all residents. The resident's diet order audit tool will be completed every year by the PCG.	11/20/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit. **FINDINGS** Resident #3 – No documented annual diet order available.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** PCG and SCG will ensure that the resident's diets are included on the signed Primary Care Provider annual review of medications. An audit tool will be completed by PCG to ensure that the required diet orders received for all residents every year.	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Vitamin D3 and Vitamin B12 supplements ordered on 7/1/2023 do not include the dose.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Resident #1 received a verification of orders for the Vitamin D3 and Vitamin B12 which include the dose for medication administration on 9/17/2023.	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Vitamin D3 and Vitamin B12 supplements ordered on 7/1/2023 do not include the dose.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Resident #1 clarification of Vitamin D3 and Vitamin B12 orders were clarified to include the medication doses for administration on 9/17/2023. All residents medication orders were audited and no other resident were identified with the same error as Resident #1. All SCG were educated on medication orders which include the doses for administration. Audit tool was completed by PCG using the medication administration record on the beginning of each month and compare to current medication orders to ensure compliance with appropriate medication orders.	10/01/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Filled prescription medication bottle without a label found with resident's medications. Pills in medication bottle were oval, red and white with P10 imprinted on them (Docusate Sodium); however, there was no medication order available for it.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Resident #1 husband brought a bottle of docusate sodium, gave to SCG and requested to get an order for administration from PCP. Orders for Docusate Sodium was clarified and obtained from PCP on 9/17/2023. All SCG educated by PCG to ensure all medications in resident's medication box has appropriate orders from PCP for administration.	10/01/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Filled prescription medication bottle without a label found with resident's medications. Pills in medication bottle were oval, red and white with P10 imprinted on them (Docusate Sodium); however, there was no medication order available for it.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Audit completed for all medications in each of the resident's medication boxes and all medication has appropriate orders form PCP. A medication box audit will be completed monthly by PCG monthly to ensure all medications available for administration has appropriate orders from PCP.	10/01/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(7) During residence, records shall include: Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency; **FINDINGS** Resident #1, #2, and #4 – Weight not taken monthly.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(7) During residence, records shall include: Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency; **FINDINGS** Resident #1, #2, and #4 – Weight not taken monthly.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** All residents will be weighted every month. Residents who are not able to stand up appropriately on a stand up weighing scale, arm circumferential will be obtained monthly. 1 arm will be used consistently for measurement every month. PCG provided education to all SCG for the monthly weight and arm measurement every month.	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (f)(1) General rules regarding records: All entries in the resident's record shall be written in black ink, or typewritten, shall be legible, dated, and signed by the individual making the entry; **FINDINGS** Resident #1 – Multiple illegible blood pressure readings in July 2023 medication administration record.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (f)(1) General rules regarding records: All entries in the resident's record shall be written in black ink, or typewritten, shall be legible, dated, and signed by the individual making the entry; **FINDINGS** Resident #1 – Multiple illegible blood pressure readings in July 2023 medication administration record.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** All BP measurement recording will be legible. PCG provided an education to all SCG on how to correct if an error occurs to ensure the BP reading logs are clean and legible at all times. Monthly audit will be completed by PCG to ensure BP reading are recorded neatly and clearly at all tiems.	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (f)(4) General rules regarding records: All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency. **FINDINGS** Resident #1 – Emergency information sheet incomplete. Missing back page with medication information.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Resident #1 emergency information sheet is completed.	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (f)(4) General rules regarding records: All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency. **FINDINGS** Resident #1 – Emergency information sheet incomplete. Missing back page with medication information.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** All resident emergency sheet has been completed. PCG provided an education to ensure the emergency information sheet is completed. Annual audit will be completed by PCG to ensure compliance.	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** General register does not include the year for multiple resident admissions and discharges.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** General Registry is completed to indicate admission, re-admission and discharges.	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** General register does not include the year for multiple resident admissions and discharges.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** PCG provided education to all SCG regarding the General Registry complettion. PCG will complete annual audit for the General Registry completion.	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-23 Physical environment. (g)(3)(D) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: A drill shall be held to provide training for residents and personnel at various times of the day or night at least four times a year and at least three months from the previous drill, and the record shall contain the date, hour, personnel participating and description of drill, and the time taken to safely evacuate residents from the building. A copy of the fire drill procedure and results shall be submitted to the fire inspector or department upon request; **FINDINGS** 7/20/2023 fire drill only included the names of 2 out of 5 residents.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-23 Physical environment. (g)(3)(D) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: A drill shall be held to provide training for residents and personnel at various times of the day or night at least four times a year and at least three months from the previous drill, and the record shall contain the date, hour, personnel participating and description of drill, and the time taken to safely evacuate residents from the building. A copy of the fire drill procedure and results shall be submitted to the fire inspector or department upon request; **FINDINGS** 7/20/2023 fire drill only included the names of 2 out of 5 residents.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** PCG will encourage resident's participation on the fire drill. Resident's refusal for the fire drill participation will be recorded and will be given a verbal discussion on the fire drill procedure as appropriate. All fire drills will be completed and recorded as appropriate.	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-83 Personnel and staffing requirements. (5) In addition to the requirements in subchapter 2 and 3: Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents. **FINDINGS** PCG, SCG #1, #2, #3, #4, and #5 – 0 out of 12 continuing education hours completed within last year.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** All 12 hour continuing education completed. SCG completed on 10/28/2023. SCG#1 completed on 11/28/2023. SCG #2 completed on 11/28/2023. SCG #3 completed on 11/28/2023. SCG #4 completed on 7/31/2023. SCG #5 completed on 11/28/23.	11/28/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-83 Personnel and staffing requirements. (5) In addition to the requirements in subchapter 2 and 3: Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents. **FINDINGS** PCG, SCG #1, #2, #3, #4, and #5 – 0 out of 12 continuing education hours completed within last year.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** 12 Hour mandatory conitnuing education will be compelted every year for all SCG and PCG. Education provided to all SCG for the completion on 12 hour cpontinuing education every year. Audit will be completed annually by PCG to ensure compliance.	11/28/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-86 Fire safety. (a)(3) A Type I expanded ARCH shall be in compliance with existing fire safety standards for a Type I ARCH, as provided in section 11-100.1-23(b), and the following: Fire drills shall be conducted and documented at least monthly under varied conditions and times of day; **FINDINGS** No fire drill conducted/documented in August 2023.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-86 Fire safety. (a)(3) A Type I expanded ARCH shall be in compliance with existing fire safety standards for a Type I ARCH, as provided in section 11-100.1-23(b), and the following: Fire drills shall be conducted and documented at least monthly under varied conditions and times of day; **FINDINGS** No fire drill conducted/documented in August 2023.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Monthly Fire drill will be conducted and recorded by PCG. PCG will educate all SCG of the required monthly fire drill. Monthly fire drill will be conducted by PCG.	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-86 Fire safety. (a)(4) A Type I expanded ARCH shall be in compliance with existing fire safety standards for a Type I ARCH, as provided in section 11-100.1-23(b), and the following: Hard wired smoke detectors shall be approved by a nationally recognized testing laboratory and all shall be tested at least monthly to assure working order; **FINDINGS** No smoke detector check completed for August 2023.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-86 Fire safety. (a)(4) A Type I expanded ARCH shall be in compliance with existing fire safety standards for a Type I ARCH, as provided in section 11-100.1-23(b), and the following: Hard wired smoke detectors shall be approved by a nationally recognized testing laboratory and all shall be tested at least monthly to assure working order; **FINDINGS** No smoke detector check completed for August 2023.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** All smoke detector were check monthly. PCG will complete the smoke detector check form for the result of the monthly smoke detector check.	09/17/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-88 Case management qualifications and services. (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: 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; **FINDINGS** Resident #1 – Per case management care plan, report to MD if systolic blood pressure is above 180. On 8/24/2023, case manager documented blood pressure as 183/112; however, no documented evidence the resident's physician was notified.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	11/27/2023

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-88 Case management qualifications and services. (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: 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; **FINDINGS** Resident #1 – Per case management care plan, report to MD if systolic blood pressure is above 180. On 8/24/2023, case manager documented blood pressure as 183/112; however, no documented evidence the resident's physician was notified.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Resident #1 The case management care plan was reviewed with the RN case manager. RN Case manager will document communication to PCP when SBP is >180. SCG/PCG will document communication to notify PCP when SBP>180. PCP/SCG will notify RN case manager of any SBP >180 and PCP recommendations.	09/17/2023

Licensee's/Administrator's Signature: maria ross

Print Name: maria ross

Date: Dec 3, 2023

Licensee's/Administrator's Signature: maria ross

Print Name: maria ross

Date: Feb 1, 2024