

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: The Good Shepherd	CHAPTER 100.1
Address: 94-265 Puamano Place, Waipahu, Hawaii 96797	Inspection Date: December 4, 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) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

STATE OF HAWAII
DEPARTMENT OF
STATE LICENSING

24 JAN 24 P 2:52

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-3 <u>Licensing</u> . (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. <u>The following shall accompany the application:</u> 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; <u>FINDINGS</u> Primary Caregiver (PCG), Substitute Caregiver (SCG) #1-8 – Current FieldPrint clearance unavailable for review. Submit a copy with plan of correction. <div style="text-align: right;"> STATE OF MICHIGAN DEPARTMENT OF STATE LICENSING </div> <div style="text-align: right;"> 24 JAN 24 P 2 \$2 </div>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>Field Print Clearances obtained 1/24/24 for PCG and all Subst. Care Givers. Pp. see attached</i></p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>. (b)(1)(I) Application.</p> <p>In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application:</p> <p>Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law;</p> <p><u>FINDINGS</u> Primary Caregiver (PCG), Substitute Caregiver (SCG) #1-8 – Current FieldPrint clearance unavailable for review.</p> <p>Submit a copy with plan of correction.</p> <p style="text-align: right;">STATE OF HAWAII DEPARTMENT OF HEALTH STATE LICENSING</p> <p style="text-align: right;">24 JAN 24 P2:53</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>posted Field Print Clearance due dates on the calendar. I will review calendar on the 1st of each month and notify SCG's to submit Field Print Clearance by the end of the month.</i></p>	<p style="text-align: center;"><i>1/24/24</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p>FINDINGS SCG #1,4 – Initial 2-step tuberculosis (TB) clearance unavailable for review.</p> <p>Submit a copy with plan of correction.</p> <p>STATE OF MARYLAND DEPARTMENT OF HEALTH STATE LICENSING</p> <p>JAN 24 2:53 PM '24</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;"><u>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</u></p> <p><i>SCG #1 - Terminated 11/30/23</i></p> <p><i>SCG #4 - 2 steps TB test obtained - See Attached 1/24/24</i></p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p>FINDINGS SCG #1,4 – Initial 2-step tuberculosis (TB) clearance unavailable for review.</p> <p>Submit a copy with plan of correction.</p> <p style="text-align: right;">STATE OF HAWAII DEPARTMENT OF HEALTH JAN 24 2024 2:53 PM</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>I created a new hire check list that includes an initial TB clearance for submission (2 steps skin test or chest X-ray)</i></p>	<p style="text-align: center;"><i>1/24/24</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><u>FINDINGS</u> SCG #5,6 – Annual TB clearance unavailable for review.</p> <p>Submit a copy with plan of correction.</p> <p style="text-align: right;">STATE OF HAWAII DEPARTMENT OF HEALTH STATE LICENSING 24 JAN 24 P 2 53</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>TB Test Clearance obtained for SCG #5 & 6 See Attached</i></p>	<p style="text-align: center;"><i>1/24/24</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p>FINDINGS SCG #5,6 – Annual TB clearance unavailable for review.</p> <p>Submit a copy with plan of correction.</p> <p style="text-align: right;">STATE OF MARYLAND DEPARTMENT OF HEALTH STATE LICENSING</p> <p style="text-align: right;">24 JAN 24 P2:53</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>I will create a reminder note on my care home Binder to review Annual TB Clearances for all Staffs 1 month prior to inspection month.</i></p>	<p style="text-align: right;"><i>1/24/24</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) 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>FINDINGS SCG #1,2 - Valid first-aid certification unavailable for review.</p> <p>Submit a copy with plan of correction.</p> <p>STATE OF HAWAII DIVISION OF STATE LICENSING 24 JAN 24 P2:53</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>SCG #1 & 2 - were terminated 11/30/23. Unable to obtain 1st Aid Certification.</p>	<p>1/24/24</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) 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>FINDINGS SCG #1,2 - Valid first-aid certification unavailable for review.</p> <p>Submit a copy with plan of correction.</p> <p>STATE LICENSING DIVISION STATE OF HAWAII</p> <p>24 JAN 24 P2:53</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>Will create a log of 1st Aid Certification Expiration Date of all staffs. Will review log each month and notify staff to submit re-certification 3 months prior to expiration.</i></p>	<p><i>1/24/24</i></p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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 #1,2,7 – PCG training on medication administration unavailable. Submit a copy with plan of correction.	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;"><u>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</u></p> <p style="text-align: center;">SCG #192 - Terminated on 11/30/23</p> <p style="text-align: center;">SCG #7 - Training for medication administration by PCG scheduled for 1/25/24</p>	<p style="text-align: right;">1/24/24</p>

STATE OF MARYLAND
DIVISION OF LICENSING

24 JAN 24 P 2:53

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) 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>FINDINGS SCG #1,2,7 – PCG training on medication administration unavailable.</p> <p>Submit a copy with plan of correction.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I created a new Hire Check List that includes PCG Training. I will use this check list as I orient new employees.</i></p>	<p style="text-align: right;"><i>1/24/24</i></p>

STATE OF HAWAII
 DEPARTMENT OF HEALTH
 STATE LICENSING
 24 JAN 24 P 2:53

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (a) All food shall be procured, stored, prepared and served under sanitary conditions.</p> <p>FINDINGS A pot of meat and separate pot of peas observed stored on kitchen stove at room temperature outside of acceptable storage temperature of <45°F or plating temperature of >135°F.</p> <p>STATE OF HAWAII DEPT. OF HEALTH STATE LICENSING 24 JAN 24 P2:53</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>Food was discarded after inspection ended.</i></p>	<p><i>1/24/24</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (a) All food shall be procured, stored, prepared and served under sanitary conditions.</p> <p>FINDINGS A pot of meat and separate pot of peas observed stored on kitchen stove at room temperature outside of acceptable storage temperature of <45°F or plating temperature of >135°F.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>I posted a reminder note on the refrigerator to not leave any food on top the stove outside of meal time. Put food away immediately after each meal</i></p>	<p style="text-align: center;"><i>1/24/24</i></p>

STATE OF MAHARASHTRA
STATE LICENSING

24 JAN 24 P 2:53

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (c) Refrigerators shall be equipped with an appropriate thermometer and temperature shall be maintained at 45°F or lower.</p> <p>FINDINGS Kitchen refrigerator temperature exceeds acceptable temperature range (<45°F) at 50°F</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;"><u>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</u></p> <p style="text-align: center;"><i>Food items were removed from refrigerator to reduce over crowding. Temperature re-check after and read at 40 degrees.</i></p>	<p style="text-align: center;"><i>1/24/24</i></p>

STATE OF HAWAII
DIVISION OF
STATE ENGINEERING

24 JAN 24 P2:53

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (c) Refrigerators shall be equipped with an appropriate thermometer and temperature shall be maintained at 45°F or lower.</p> <p>FINDINGS Kitchen refrigerator temperature exceeds acceptable temperature range (<45°F) at 50°F</p> <p>STATE OF MARYLAND DEPARTMENT OF HEALTH STATE LICENSING</p> <p>24 JAN 24 P2:53</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>all staffs in-service on checking refrigerator temperature each morning to ensure it's under 45 degrees. If above staff instructed to notify PCG.</i></p>	<p><i>11/24/24</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (b) 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> Unlabeled medications (Dayquil, Nyquil, ZZZquil, Miralax, Metamucil, elderberry supplement, Senokot) stored in medication cabinet.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;"><u>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</u></p> <p style="text-align: center;"><i>Unlabelled medications removed from cabinet.</i></p>	<p style="text-align: center;"><i>1/24/24</i></p>

STATE OF MICHIGAN
 STATE OF MICHIGAN
 24 JAN 24 P2 54

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (b) 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> Unlabeled medications (Dayquil, Nyquil, ZZZquil, Miralax, Metamucil, elderberry supplement, Senokot) stored in medication cabinet.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>Reminder note posted on medication cabinet to double check medications include a proper label before storing in the cabinet.</i></p>	<p style="text-align: center;"><i>1/24/24</i></p>

STATE OF HAWAII
 DEPARTMENT OF HEALTH
 STATE LICENSING

24 JAN 24 P 2:54

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year.</p> <p>FINDINGS Resident #1 – No documented evidence medication orders were reevaluated and signed by the resident's physician.</p> <p>Submit a copy with plan of correction.</p> <p style="text-align: right;">STATE OF MARYLAND STATE LICENSING JAN 24 2024 2:54 PM</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>See +</i></p> <p style="text-align: center;"><i>Resident #1 – renewed medications ordered obtained. See Attached</i></p>	<p style="text-align: center;"><i>1/24/24</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year.</p> <p><u>FINDINGS</u> Resident #1 – No documented evidence medication orders were reevaluated and signed by the resident’s physician.</p> <p>Submit a copy with plan of correction.</p> <p>STATE OF MARYLAND GOVERNMENT STATE LICENSING</p> <p>24 JAN 24 P 2:54</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>Reminder note placed on resident binder to obtain updated medication order every 4 months.</i></p>	<p style="text-align: right;"><i>1/24/24</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>11-100.1-17 <u>Records and reports.</u> (a)(1) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>Documentation of primary care giver's assessment of resident upon admission;</p> <p>FINDINGS Resident #1 – PCG assessment unavailable for review</p> <p>Submit a late entry copy with plan of correction.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>Resident #1 - Late entry PCG assessment completed. See attached.</i></p>	<p style="text-align: center;"><i>1/24/24</i></p>

STATE OF MAINE
DEPARTMENT OF LICENSING
24 JAN 24 P 2:54

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> 11-100.1-17 <u>Records and reports.</u> (a)(1) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Documentation of primary care giver's assessment of resident upon admission; <u>FINDINGS</u> Resident #1 – PCG assessment unavailable for review Submit a late entry copy with plan of correction.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>I created a new Admission Check List that includes completing a PCG assessment upon admission. I will utilize checklist at each admission.</i></p>	<p style="text-align: center;"><i>#24/24</i></p>

STATE OF MICHIGAN
 DEPT. OF HEALTH
 STATE LICENSING

24 JAN 24 P2:54

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs;</p> <p><u>FINDINGS</u> Resident #1 – Monthly progress notes do not include resident's response to medications and diet.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p>23 DEC 18 P12:55</p>

STATE OF HAWAII
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HEALTH
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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include:</p> <p>Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs:</p> <p>FINDINGS</p> <ul style="list-style-type: none"> Resident #1 - Monthly progress notes do not include resident's response to medications and diet. <p style="text-align: right;">STATE OF KANSAS STATE LICENSING 24 JUN 24 P2:54</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>Reminder notes placed on residents binder to include response to medications and diet on monthly progress note.</i></p>	<p style="text-align: right;"><i>1/24/24</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-19 <u>Resident accounts.</u> (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative.</p> <p>FINDINGS Resident #1 – Signed financial agreement unavailable for review.</p> <p>Submit a copy with plan of correction.</p> <p>STATE OF HAWAII DEPARTMENT OF HEALTH STATE LICENSING</p> <p>JAN 24 2:54 PM '24</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>Resident #1 - Financial Agreement completed and filed. See Attached.</i></p>	<p style="text-align: center;"><i>1/24/24</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-19 <u>Resident accounts.</u> (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative.</p> <p>FINDINGS Resident #1 - Signed financial agreement unavailable for review.</p> <p>Submit a copy with plan of correction.</p> <p style="text-align: right;">STATE OF HAWAII HONOLULU STATE LICENSING</p> <p style="text-align: right;">24 JAN 24 P 2:54</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I created a new Admission Check List that includes assigned financial agreement to be completed. Will utilize this check list for new admission.</i></p>	<p style="text-align: right;"><i>1/24/24</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(D) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>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;</p> <p><u>FINDINGS</u> No documented fire drills performed during hours of darkness.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p> <p style="text-align: right;">STATE OF CONNECTICUT STATE LICENSING</p>	<p style="text-align: right;">'23 DEC 18 P12:55</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(D) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>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;</p> <p><u>FINDINGS</u> No documented fire drills performed during hours of darkness.</p> <p>STATE OF MARYLAND DEPT. OF GENERAL SERVICES STATE LICENSING 24 JAN 24 P2:54</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>Reminder note posted on Care Home Binder to perform some Fire Drills during hours of darkness.</i></p>	<p style="text-align: center;"><i>1/24/24</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (h) 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><u>FINDINGS</u> SCG #2 reports using only dish soap to wash dishes as their sanitizing process.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p> <p style="text-align: right;">STATE OF HAWAII DEPARTMENT OF HEALTH STATE LICENSING</p>	<p>23 DEC 10 PM 2:55</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 Physical environment. (h) 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>FINDINGS SCG #2 reports using only dish soap to wash dishes as their sanitizing process.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>all staff ^{were} was in serviced on proper sanitizing process for dishes and utensils. Staff instructed to follow this process when handling dishes.</i></p>	<p style="text-align: center;"><i>1/24/24</i></p>

STATE OF MARYLAND
DOH - DCA
STATE LICENSING

24 JAN 24 P2:54

Licensee's/Administrator's Signature: The Good Shepherd LLC - *Zennia Agpaga*

Print Name: Zennia Agpaga

Date: 12/15/23

STATE OF HAWAII
DEPT. OF
STATE LICENSING

23 DEC 18 PM 2:55

Licensee's/Administrator's Signature: *Jen Aggar*

Print Name: Fennia Aggar

Date: 1/24/24

STATE OF HAWAII
DWM DIVISION
STATE LICENSING

24 JAN 24 P 2:54