

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Downey, Norma	CHAPTER 100.1
Address: 4038 Salt Lake Boulevard, Honolulu, Hawaii	Inspection Date: September 11, 2024 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 PER HAR 11-100.1-3(e)(2). IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

**FAILURE TO CORRECT CITED DEFICIENCIES AS PER THE PLAN OF CORRECTION COULD RESULT IN REFUSAL TO RENEW YOUR LICENSE PER HAR 11-100.1-3(e)(3).**

	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><b><u>FINDINGS</u></b>  Primary Care Giver (PCG), Substitute Care Giver (SCG) #1, House Hold Member (HHM) #1 – No documented evidence that aforementioned care givers have no prior felony or abuse convictions in a court of law.</p> <p><b><u>Please submit copy of Fieldprint background check clearances with Plan of Correction.</u></b></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>Primary Care Giver, — 10/27/2023  Substitute Care Giver — 9/28/2023  and Household member  did their background  check and finger printing. } 12/2023  field printing updated — 5/28/2024  6/27/2025</p>	

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<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><b>FINDINGS</b> PCG, SCG #1, HHM #1 – No documented evidence that aforementioned care givers have no prior felony or abuse convictions in a court of law.</p> <p><u>Please submit copy of Fieldprint background check clearances with Plan of Correction.</u></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>PCG appt Schedule with field print — 10/27/2023</p> <p>SCG #1 — received determination of background check — 9/28/2023</p> <p>— SCG #1 appealed the red light and got green light in — 12/2023</p> <p>— HHM #1 received green light — 5/28/2024</p> <p><u>Correction:</u></p> <p>Once PCG Received the fieldprint background check from SCG #1 and HHM #1 in the file as required — 6/22/2025</p> <p>SCG will double check info in file — 6/27/2025</p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p><b>FINDINGS</b> SCG #1, HHM #1 – No documented evidence of a current annual physical examination clearance from a physician or APRN.</p> <p><u>Please submit copy of physical examination clearances with Plan of Correction.</u></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>Grave and asked SCG #1 and HHM #1 have their physician/dn to fill out the updated physical exam</i></p> <p><i>PE Exam completed &amp; filed</i></p>	<p><i>9/1/2024</i></p> <p><i>6/27/2025</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> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p><b><u>FINDINGS</u></b> SCG #1, HHM #1 – No documented evidence of a current annual physical examination clearance from a physician or APRN.</p> <p><b><u>Please submit copy of physical examination clearances with Plan of Correction.</u></b></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>received annual physical exam clearance from SCG #1 – 11/19/2024</i></p> <p><i>received annual physical exam clearance from HHM #1 – 6/18/2025</i></p> <p><i>Plan of Correction:</i></p> <p><i>Explained and told SCG #1 and HHM #1 that there is a due date forms need to be turn in. forms need to be in their file before 8/31/2024. Both SCG #1 and HHM #1 will comply with D.OH requirement – 6/21/2025</i></p> <p><i>SCG #1 will review every 6 months on file 6/27/2025</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><b><u>FINDINGS</u></b> SCG #1, HHM #1 – No documented evidence of a current annual tuberculosis clearance from a physician or APRN.</p> <p><b><u>Please submit copy of tuberculosis clearances with Plan of Correction.</u></b></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>SCG #1 received annual TB clearance from physician / APRN ———</p> <p>HHM #1 received annual TB clearance from physician / APRN ———</p>	<p>11/19/2024</p> <p>6/18/2025</p>

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<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><b><u>FINDINGS</u></b> SCG #1, HHM #1 – No documented evidence of a current annual tuberculosis clearance from a physician or APRN.</p> <p><b><u>Please submit copy of tuberculosis clearances with Plan of Correction.</u></b></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>told and explained to SCG #1 and HHM #1 need required annual TB clearance and put it into their file before 8-31-2025 to comply with D.O.H requirement — 6/21/2025</p> <p>SCG will check every 6 months off file — 6/27/2025</p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms.</p> <p><u>FINDINGS</u> Resident #1 – Observed “daytime” cough syrup, “nighttime” cough syrup, and “allergy” medication bottles on resident’s dresser, unlabeled and unsecured.</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>Conf's labeled "daytime" and "nighttime" cough syrup, and allergy medication bottles on resident's dresser — and put it in the medicine cabinet</i></p>	<p><i>6/19/2025</i></p>



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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (1) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.</p> <p><b><u>FINDINGS</u></b> Resident #1 – Observed “daytime” cough syrup, “nighttime” cough syrup, and “allergy” medication bottles on resident’s dresser, unlabeled and unsecured.</p>	<p align="center"><b>PART 1</b></p> <p align="center"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p align="center"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p align="center"> <i>confiscated cough syrup and allergy medication from resident's dresser i put it in a second cabinet — 6/19/2025</i> </p>	<p align="center">6/19/2025</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.</p> <p><b><u>FINDINGS</u></b> Resident #1 – Observed “daytime” cough syrup, “nighttime” cough syrup, and “allergy” medication bottles on resident’s dresser, unlabeled and unsecured.</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>put all O-T-C (over the counter) cough syrup and allergy medication in a secured medicine cabinet - 6/19/2025</p> <p>SG will do daily rounds - 6/27/2025</p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><b><u>FINDINGS</u></b> Resident #2 – No documented evidence of a current physical examination clearance by a physician or APRN on file.</p> <p><b><u>Please submit copy of current physical examination clearance documentation with Plan of Correction.</u></b></p>	<p align="center"><b>PART 1</b></p> <p align="center"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p align="center"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p align="center"><i>physical completed in file</i></p>	<p align="center"><i>6/27/2025</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p> <p><b><u>FINDINGS</u></b> Resident #2 – No documented evidence of a current tuberculosis clearance by a physician or APRN on file.</p> <p><b><u>Please submit copy of current tuberculosis clearance documentation with Plan of Correction.</u></b></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 style="text-align: center;"><i>Completed 5 TB Clearance<sup>1</sup> on file 6/27/2025</i></p>	<p style="text-align: center;"><i>6/27/2025</i></p>

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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> (f)(1) General rules regarding records:</p> <p>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;</p> <p><b><u>FINDINGS</u></b> Resident #3 – Observed use of purple ink on January 2024 medication administration record (MAR) entries.</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>9-10-2024</p>



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<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (f)(1) General rules regarding records:</p> <p>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;</p> <p><b><u>FINDINGS</u></b> Resident #3 – Observed use of purple ink on January 2024 MAR entries.</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>all colored pens thrown away and only will be using black ink pen as required</i></p> <p><i>SCG will double check in daily round</i></p>	<p><i>6/19/2025</i></p> <p><i>6/27/2025</i></p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-19 <u>Resident accounts.</u> (d)            An accurate written accounting of resident's money and disbursements shall be kept on an ongoing basis, including receipts for expenditures, and a current inventory of resident's possessions.</p> <p><b><u>FINDINGS</u></b>            Resident #1, Resident #2, Resident #3, Resident #4 – No documented evidence of a current inventory of belongings on file for department review.</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 style="text-align: center;"><i>took updated inventory of the residents's belongings</i></p>	<p style="text-align: center;"><i>- 6/19/2025</i></p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-19 <u>Resident accounts</u>, (d) An accurate written accounting of resident's money and disbursements shall be kept on an ongoing basis, including receipts for expenditures, and a current inventory of resident's possessions.</p> <p><b><u>FINDINGS</u></b> Resident #1, Resident #2, Resident #3, Resident #4 – No documented evidence of a current inventory of belongings on file for department review.</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>PCG will be taking and documenting all residents's belongs and put inventory form in the residents's file</i> — 6/19/2025</p> <p><i>SCG will double check every 6 months</i> — 6/27/2025</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 1 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><b><u>FINDINGS</u></b> No documented evidence of quarterly fire drills within prior twelve (12) months.</p> <p><u>Please submit copy of current quarter's fire drill documentation with Plan of Correction.</u></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>Current fire drills on file —</i></p>	<p><i>6/27/2025</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><b>FINDINGS</b> No documented evidence of quarterly fire drills within prior twelve (12) months.</p> <p><u>Please submit copy of current quarter's fire drill documentation with Plan of Correction.</u></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>SCG will double check every 6 months that its current is on file - 6/27/2025</i></p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(I)(i) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either:</p> <p>For each such non-certified resident there must be a responsible adult on the premises of the home at all times that the non-certified resident is present in the home, and there must never be a stairway which must be negotiated for emergency exit by such non-certified resident;</p> <p><b><u>FINDINGS</u></b> Resident #2, Resident #3, Resident #4 – No documented evidence of a current self-preservation evaluation by a physician or APRN.</p> <p><b><u>Please submit copy of current self-preservation evaluation documentation with Plan of Correction.</u></b></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>CONTACTED resident #1, resident #2, resident #3, resident #4 physicians/ APRN to fill out the Self-preservation evaluation forms. Some residents was filed separately in their file —</p>	<p>6/20/25</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(1)(i) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either:</p> <p>For each such non-certified resident there must be a responsible adult on the premises of the home at all times that the non-certified resident is present in the home, and there must never be a stairway which must be negotiated for emergency exit by such non-certified resident;</p> <p><b><u>FINDINGS</u></b> Resident #2, Resident #3, Resident #4 – No documented evidence of a current self-preservation evaluation by a physician or APRN.</p> <p><b><u>Please submit copy of current self-preservation evaluation documentation with Plan of Correction.</u></b></p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><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>When residents's see their physician for their annual physical examination / TB.</i></p> <p><i>Will have all forms attached on the P.E form and will not file &amp; separated the self-preservation statement</i></p>	<p><i>8/19/2025</i></p>

Licensee's/Administrator's Signature: Norma Downey

Print Name: NORMA DOWNEY

Date: 6/27/2025