

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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| Facility's Name: Mana's Adult Care | CHAPTER 100.1 |
| Address: 92-1177 Puconani Street Kapolei, Hawaii 96707 | Inspection Date: October 17, 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. 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 |
|-------------------------------------|--|---|-----------------------|
| <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><u>FINDINGS</u> Substitute care giver #2: No documented evidence of annual physical exam.</p> | <p>PART I</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>Substitute care Giver #2 Annual P.E. was done 12/5/24.</i></p> | <p><i>3/24/25</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><u>FINDINGS</u> Substitute care giver #2: No documented evidence of annual physical exam.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will do a checklist to remind myself 2 months before the Annual Physical Exams due ^{date} of my Substitute Care Givers.</i></p> | <p>3/24/25</p> |

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|-------------------------------------|--|---|-----------------|
| <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><u>FINDINGS</u> Resident #4: No documented evidence of annual physical exam.</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>PCG got a copy of Resident #4 Physical exam dated 11-15-2024 3/24/25</i></p> | |

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| <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><u>FINDINGS</u> Resident #4: No documented evidence of annual physical exam.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will review my residents records 2 months before it's due and inspection check.</i></p> | <p>3/24/25</p> |

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| <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><u>FINDINGS</u> Resident #5: No documented evidence of annual physical exam.</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>PCG got a copy of Resident #5 Annual Physical Exam dated 7/01/2024.</i></p> | <p><i>3/24/25</i></p> |

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| <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><u>FINDINGS</u> Resident #5: No documented evidence of annual physical exam.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will review my Resident # 5 Annual Physical Exam 2 months before its due date and before the Inspection.</i></p> | <p><i>3/24/25</i></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> (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> Resident #1: no documented evidence of annual TB clearance.</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>Resident #1 Annual TB clearance was done dated 10/22/2024.</i></p> | <p><i>3/24/25</i></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>FINDINGS Resident #1: no documented evidence of annual TB clearance.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will monitor & do a checklist to remind myself to check all the documents by my residents Annual TB Clearances before its due. I will review records 2 months before inspection.</i></p> | <p><i>3/24/25</i></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><u>FINDINGS</u> Substitute care giver #1: no documented evidence of annual TB clearance.</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>Substitute Care Giver #1</i> <i>Annual TB clearance was</i> <i>done dated 10/23/24.</i></p> | <p style="text-align: center;"><i>3/24/25</i></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><u>FINDINGS</u> Substitute care giver #1: no documented evidence of annual TB clearance.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will do a checklist to remind myself to check my Substitute Care Givers Annual TB clearance in 2 months before the due date and before the inspection.</i></p> | <p>3/24/25</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><u>FINDINGS</u> Substitute care giver #2: no documented evidence of annual TB clearance.</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>Substitute Care Giver # 2 Annual TB clearance was done dated 6/11/24.</i></p> | <p><i>3/24/25</i></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><u>FINDINGS</u> Substitute care giver #2: no documented evidence of annual TB clearance.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will do a checklist to remind myself to check my Substitute Caregivers Annually TB clearances before the due date I will review records 2 months before Inspection 3/24/25</i></p> | |

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| <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 #4: No documented evidence of progress notes for the year 2024.</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>Resident #4 progress notes for year 2024 is up to date monthly; now and corrected. 3/24/25</i></p> | |

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| <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 #5: No documented evidence of progress notes for the year 2024.</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>Resident #5 Progress notes for year 2024 is up to date monthly and corrected. 3/24/25</i></p> | |

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| <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 #5: No documented evidence of progress notes for the year 2024.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will remind myself & do checklist to check and do monthly on Resident #5 and to the rest of my residents progress notes</i></p> | <p><i>3/24/25</i></p> |

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| <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: no documented evidence of progress notes for the month of September 2024.</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>Sept. 2024</i> <i>Resident #1, progress note was corrected and done, after the inspection date (10/17/24)</i></p> | <p>3/24/25</p> |

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| <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: no documented evidence of progress notes for the month of September 2024.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will do my checklist and to remind myself to document monthly Resident #1 Progress notes.</i></p> | <p>3/24/25</p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-13 <u>Nutrition.</u> (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.</p> <p><u>FINDINGS</u> Resident #4: No annual diet order.</p> | <p>PART I</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>Resident #4 diet order from her Physician was done dated 11/15/24.</i></p> | <i>3/24/25</i> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-13 <u>Nutrition</u>. (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.</p> <p><u>FINDINGS</u> Resident #4: No annual diet order.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will be monitoring and to do my checklists to remind myself 2 months before the Annual date of Resident #4 diet order from her Physician. 3/24/25</i></p> | |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-13 <u>Nutrition.</u> (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.</p> <p><u>FINDINGS</u> Resident #5: No annual diet order.</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>PCG got a copy of Resident #5 Annual diet order from his physician; dated 7/01/24.</p> | 3/24/25 |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-13 <u>Nutrition.</u> (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.</p> <p><u>FINDINGS</u> Resident #5: No annual diet order.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will monitor & do a checklist to remind myself to check Resident #5 Annual diet order from his Physician 2 months before its due date.</i></p> | <p>3/24/25</p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications.</u> (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><u>FINDINGS</u> Resident #4: October MAR blank from the 1st to the 17th.</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>Resident #4 October MAR is corrected and filled in the blank after the inspection date.</i></p> <p><i>10/17/24.</i></p> | <p><i>3/24/25</i></p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications</u>. (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><u>FINDINGS</u> Resident #4: October MAR blank from the 1st to the 17th.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will do my checklist & remind myself to check and document daily Resident #4 October MAR and to the rest of the months.</i></p> <p><i>I will review records 2 months before the Inspection.</i></p> | <p>3/24/25</p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-15 <u>Medications.</u> (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><u>FINDINGS</u> Resident #5: October MAR prefilled.</p> | <p align="center">PART 1</p> <p align="center"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p align="center">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p align="center"><i>PCG Corrected Resident #5</i> <i>OCTober MAR dated</i> <i>10/17/24.</i></p> | <p align="center"><i>3/24/25</i></p> |

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| <input checked="" type="checkbox"/> | <p>§11-100 1-15 <u>Medications</u>, (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident</p> <p><u>FINDINGS</u> Resident #5: October MAR prefilled.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will do my checklist to remind myself and to document daily Res. #5</i></p> <p><i>I will check & review residents records 2 months before the inspection.</i></p> | <p>3/24/25</p> |

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| <input checked="" type="checkbox"/> | <p>§ 11-100.1-17 <u>Records and reports.</u> (b)(4) During residence, records shall include:</p> <p>Entries describing treatments and services rendered;</p> <p><u>FINDINGS</u> Resident #4 No documented evidence of services rendered to resident for the 2024, no progress notes from December 2023 to October 2024.</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>Resident # 4 Progress notes from Dec. 2023 to Oct. 2024 was filled and corrected after the inspection date. 10/17/24.</i></p> | <p><i>3/24/25</i></p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports</u>, (b)(4) During residence, records shall include:</p> <p>Entries describing treatments and services rendered;</p> <p><u>FINDINGS</u> Resident #4: No documented evidence of services rendered to resident for the 2024, no progress notes from December 2023 to October 2024.</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>PCG will be maintaining monthly and documenting Res #4 Progress Notes. I will review ^{records} 2 months before inspection date.</i></p> | <p><i>3/24/25</i></p> |

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| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (b)(4) During residence, records shall include:</p> <p>Entries describing treatments and services rendered;</p> <p><u>FINDINGS</u> Resident #5: No documented evidence of services rendered to resident for the 2024, no progress notes from December 2023 to October 2024.</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>Resident #5 Dec. 2023 to Oct. 2024 ^{Progress notes} were corrected after the Inspection date 10/17/24.</p> | 3/24/25 |

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|-------------------------------------|--|---|-----------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-17 <u>Records and reports.</u> (b)(4) During residence, records shall include:</p> <p>Entries describing treatments and services rendered:</p> <p><u>FINDINGS</u> Resident #5: No documented evidence of services rendered to resident for the 2024, no progress notes from December 2023 to October 2024.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will be maintaining monthly and documenting Res. #5 - Progress Notes I will review records 2 months before the Inspection.</i></p> | <p>3/24/25</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><u>FINDINGS</u> Resident #4: White out used in September 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>PCG changed and corrected White out for Res. #4 Sept. MAR. on the date of Inspection. 10/17/24 -</p> | <p>3/24/25</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><u>FINDINGS</u> Resident #4: White out used in September 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><i>PCG will make a check list and reminders not to use white out on Records of ^{all} Residence.</i></p> | <p><i>3/24/25</i></p> |

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|-------------------------------------|---|---|-----------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-23 <u>Physical environment</u> (p)(5) 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><u>FINDINGS</u> No signaling device in in bathroom #1.</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>PCG changed right away Signaling Device in Bathroom #1 - in the Inspection date - (10/17/24)</p> | 3/24/25 |

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|-------------------------------------|---|--|-----------------|
| <input checked="" type="checkbox"/> | <p>§11-100.1-23 <u>Physical environment.</u> (p)(5) 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><u>FINDINGS</u> No signaling device in in bathroom #1.</p> | <p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will do reminder checklist to always check monthly signaling device of my residences to use for their safety.</i></p> | <p>3/24/25</p> |

Licensee's/Administrator's Signature: Arlene S. Mann

Print Name: ARLENE S. MANN

Date: 12/20/24 3/24/25