Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Regency Hualalai	**CHAPTER 90**
Address: **75-181 Hualalai Road, Kailua-Kona Hawaii 96740**	**Inspection Date: April 23 & 24, 2025 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
☒	§11-90-3 Licensing (o)(10)(D) Applications for licensure shall be made to the department on a form provided by the department and shall include full and complete information as follows: Evidence that the premises comply with state and county building, housing, fire, and other codes, ordinances, and laws for the type of occupancy to be licensed. Compliance shall include but not be limited to the following: Applicable state laws and administrative rules relating to sanitation, health, and environmental safety. **FINDINGS** Annual (2025) fire extinguisher inspections not completed to ensure compliance with state and county building, housing, and fire codes or ordinances. Last done 4/17/24. *Submit a copy of the inspection reports with your plan of correction (POC).*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The annual Fire Extinguisher deficiency has been corrected. The inspection was scheduled far in advance of the month that it was due and subsequently was conducted within the month it was due on 5/23/2025. The inspection is evidence that our fire extinguishers are 100% compliant with state & county fire codes. Please see the attached Report.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-3 Licensing (o)(10)(D) Applications for licensure shall be made to the department on a form provided by the department and shall include full and complete information as follows: Evidence that the premises comply with state and county building, housing, fire, and other codes, ordinances, and laws for the type of occupancy to be licensed. Compliance shall include but not be limited to the following: Applicable state laws and administrative rules relating to sanitation, health, and environmental safety. **FINDINGS** Annual (2025) fire extinguisher inspections not completed to ensure compliance with state and county building, housing, and fire codes or ordinances. Last done 4/17/24.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** To ensure that the Annual fire extinguisher inspection is completed on or before the due date the following monitoring will be maintained and reviewed every month: #1: A life safety & fire code compliance software which tracks due dates and outlines code requirements will be utilized. #2: Scheduling of inspections will be done at least 60 days in advance of Life/fire safety compliance due dates. Please note: The Facilities Director & Executive Director will be responsible for oversight of the monitoring, scheduling & fire code compliance. See attached: 2025 Annual Fire extinguisher Inspection & corrections.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-5 Emergency care and disaster planning. (a)(4) There shall be written policies and procedures to follow in an emergency which shall include provisions for the following: Quarterly rehearsal of emergency evacuation plans for staff and residents to follow in case of fire, explosion, or other civil emergency occurring in or within the environs of the facility. **FINDINGS** There is no documented evidence of a quarterly fire drill performed between April 2024 and November 2024.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-5 Emergency care and disaster planning. (a)(4) There shall be written policies and procedures to follow in an emergency which shall include provisions for the following: Quarterly rehearsal of emergency evacuation plans for staff and residents to follow in case of fire, explosion, or other civil emergency occurring in or within the environs of the facility. **FINDINGS** There is no documented evidence of a quarterly fire drill performed between April 2024 and November 2024.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** The Quarterly Fire Drills have been conducted regularly since December 2024. Additionally, evidence of a fire drill was submitted that had been conducted between April & November of 2024. To ensure quarterly fire drills are conducted by their respective compliance due dates the following measures will be taken: #1: A life safety & fire code compliance software which tracks due dates and outlines code requirements will be utilized. #2: Scheduling of fire drills will be done at least 30 days prior to actual drills. Please note: The Facilities Director & Executive Director will be responsible for Oversight of the monitoring, scheduling & conducting of fire drills.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-6 General policies, practices, and administration. (c) All staff shall be trained in cardiopulmonary resuscitation and first aid. **FINDINGS** Employee #3, and #4 – No documentation of certifications for first aid and cardiopulmonary resuscitation (CPR). *Submit a copy with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, this deficiency was corrected. All new hires and any current staff members without or with expired CPR/First Aid certification are required to attend the CPR/Aid classes to receive current certification status. Copies of the certification are kept on file at the community. See the attached.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-6 General policies, practices, and administration. (c) All staff shall be trained in cardiopulmonary resuscitation and first aid. **FINDINGS** Employee #3, and #4 No documentation of certifications for first aid and cardiopulmonary resuscitation (CPR).	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Please see the attached. All new hires and current staff members without this Certification or expired Certification are required to attend a CPR/First Aid class. These classes are held weekly. There is a Tracking document that is held between the RCC and BOD to manage this process on a weekly basis. Both RCC and BOD are trained on this new and comprehensive process to ensure each employee has all required documentation completed BEFORE they are eligible to work on the floor.	07/31/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-7 Inservice education. (1) There shall be a staff inservice education program for the entire staff that includes: Orientation for all new employees to acquaint them with the philosophy, organization, practice, and goals of assisted living; **FINDINGS** Employee #1, and #2 - No documentation that employees completed the facility's general orientation to acquaint them with the philosophy, organization, practice, and goals of assisted living. *Submit a copy with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, the deficiency has been corrected. New Hire Orientation is held weekly on Wednesdays from 8:30 am – 10 am, then 1:30 - 3:30pm for all new hires. During this time, each new hire is educated by each manager on the philosophies, organizational practices, and goals of assisted living, as well as company policies and interactions with residents. All new hires are required to attend orientation before they can start on the floor with their new department. Employees and managers must initial and date on the checklist provided and return it to the Business Office Manager, copies of this check are kept in each employee file. See the attached.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-7 Inservice education. (1) There shall be a staff inservice education program for the entire staff that includes: Orientation for all new employees to acquaint them with the philosophy, organization, practice, and goals of assisted living; **FINDINGS** Employee #1, and #2 - No documentation that employees completed the facility's general orientation to acquaint them with the philosophy, organization, practice, and goals of assisted living.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Please see the attached. The BOD is responsible for monitoring the Tracking documentation on a weekly basis to ensure each employee has met all general orientation items for working in the community. The BOD has been trained to manage this new and comprehensive general orientation process, which includes the philosophy, organization, practice and goals of Assisted Living.	07/31/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-7 Inservice education. (1) There shall be a staff inservice education program for the entire staff that includes: Orientation for all new employees to acquaint them with the philosophy, organization, practice, and goals of assisted living; **FINDINGS** Employee #3 was hired on 11/29/24; however, facility orientation was completed on 4/23/25, five months after the hire date.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-7 Inservice education. (1) There shall be a staff inservice education program for the entire staff that includes: Orientation for all new employees to acquaint them with the philosophy, organization, practice, and goals of assisted living; **FINDINGS** Employee #3 was hired on 11/29/24; however, facility orientation was completed on 4/23/25, five months after the hire date.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** The BOD/HR Director is responsible for ensuring that new staff orientation is completed upon hire BEFORE working on the floor. The BOD has worked with the VP of HR to ensure that all orientation processes meet state compliance regulations.	07/31/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-7 Inservice education. (2) There shall be a staff inservice education program for the entire staff that includes: Ongoing inservice training on a regularly scheduled basis (minimum of six hours annually). **FINDINGS** No documented evidence that kitchen and dietary staff were provided training on special diets, food values, and nutrition by the facility dietician.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, the deficiency has been corrected. The Executive Chef worked directly with the Registered Dietician on special diets training, including food values and nutrition.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-7 Inservice education. (2) There shall be a staff inservice education program for the entire staff that includes: Ongoing inservice training on a regularly scheduled basis (minimum of six hours annually). **FINDINGS** No documented evidence that kitchen and dietary staff were provided training on special diets, food values, and nutrition by the facility dietician.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Please see the attached. The new Executive Chef will conduct quarterly in-service trainings on modified diets, food values, and nutrition. The new EC has been trained by the RD on all protocols to ensure compliance with state standards. The EC will track all in-services and keep a binder in ofc to display compliance.	07/31/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (a)(1) Service plan. The assisted living facility staff shall conduct a comprehensive assessment of each resident's needs, plan and implement responsive services, maintain and update resident records as needed, and periodically evaluate results of the plan. The plan shall reflect the assessed needs of the resident and resident choices, including resident's level of involvement; support principles of dignity, privacy, choice, individuality, independence, and home-like environment; and shall include significant others who participate in the delivery of services; **FINDINGS** Resident #4 – No documentation of comprehensive assessment completed following readmission on 10/16/24.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (a)(1) Service plan. The assisted living facility staff shall conduct a comprehensive assessment of each resident's needs, plan and implement responsive services, maintain and update resident records as needed, and periodically evaluate results of the plan. The plan shall reflect the assessed needs of the resident and resident choices, including resident's level of involvement; support principles of dignity, privacy, choice, individuality, independence, and home-like environment; and shall include significant others who participate in the delivery of services; **FINDINGS** Resident #4 – No documentation of a comprehensive assessment completed following readmission on 10/16/24.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** When a resident is re-admitted to the community after an absence, a comprehensive assessment is completed by the DON or Community RN prior to re-admission to the facility or upon immediate return to the facility. If a licensed nurse is not in the facility at the time a resident returns, the on-call nurse is contacted to receive the report. Any care changes will be added to the Service Plan via the ISP reflecting the necessary changes. The assessment will be completed the very next day when a nurse is in the facility. The DON will audit the need for comprehensive assessments through the 24-72 hour daily report. The assessment will be recorded in the electronic record. The DON will in-service the Community Nurse on this process.	07/31/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (a)(2) Service plan. A service plan shall be developed and followed for each resident consistent with the resident's unique physical, psychological, and social needs, along with recognition of that resident's capabilities and preferences. The plan shall include a written description of what services will be provided, who will provide the services, when the services will be provided, how often services will be provided, and the expected outcome. Each resident shall actively participate in the development of the service plan to the extent possible; **FINDINGS** Resident #1 – Current service plan indicates resident is independent with medication management; however, the facility administers medications as documented on the electronic medication administration record (eMAR). *Submit revised service plan with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, this deficiency was corrected. On 10/5/2024, the Director of Nursing revised the comprehensive assessment to reflect the change in medication administration from self-administered to facility administered. This information was updated in the service plan. On 4/2025, the information stating self-administration was deleted from the service plan. Please see the attached revised service plan.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (a)(2) Service plan. A service plan shall be developed and followed for each resident consistent with the resident's unique physical, psychological, and social needs, along with recognition of that resident's capabilities and preferences. The plan shall include a written description of what services will be provided, who will provide the services, when the services will be provided, how often services will be provided, and the expected outcome. Each resident shall actively participate in the development of the service plan to the extent possible; **FINDINGS** Resident #1 – Current service plan indicates resident is independent with medication management; however, the facility administers medications as documented on the electronic medication administration record (eMAR).	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** When updating a resident service plan, the Licensed Nurse will review the service plan to ensure all incorrect information is deleted upon change of service. The Director of Nurses will in-service the Community Nurse on this process.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (a)(3) Service plan. The initial service plan shall be developed prior to the time the resident moves into the facility and shall be revised if needed within 30 days. The service plan shall be reviewed and updated by the facility, the resident, and others as designated by the resident at least annually or more often as needed; **FINDINGS** Resident #1 – Service plan was not updated to reflect the current diet order, 1800 ADA diet ordered on 9/19/2024. *Submit a copy of the revised care plan with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, this deficiency was corrected. On 9/20/2024, the Director of Nurses added 1800 ADA diet information to the service plan and 1800 ADA education was also provided to the resident at that time. The actual diet order has now been updated to say 1800 ADA in "additional information." Please see the attached revised service plan.	7/18/2025

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☒	§11-90-8 Range of services. (a)(3) Service plan. The initial service plan shall be developed prior to the time the resident moves into the facility and shall be revised if needed within 30 days. The service plan shall be reviewed and updated by the facility, the resident, and others as designated by the resident at least annually or more often as needed; **FINDINGS** Resident #1 – Service plan was not updated to reflect the current diet order, 1800 ADA diet ordered on 9/19/2024.	**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 diet orders will be transcribed exactly as written by physician. Orders will go through the triple check system, reviewed by the Community RN, the Resident Care Coordinator, and the Director of Nurses to ensure accuracy. The Director of Nurses will in-service the Community Nurse and the Resident Care Coordinator on this process.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (a)(3) Service plan. The initial service plan shall be developed prior to the time the resident moves into the facility and shall be revised if needed within 30 days. The service plan shall be reviewed and updated by the facility, the resident, and others as designated by the resident at least annually or more often as needed; **FINDINGS** Resident #4 - No documentation service plan was reviewed and/or updated following readmission on 10/16/24. Service plan was updated on 12/10/24.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (a)(3) Service plan. The initial service plan shall be developed prior to the time the resident moves into the facility and shall be revised if needed within 30 days. The service plan shall be reviewed and updated by the facility, the resident, and others as designated by the resident at least annually or more often as needed; **FINDINGS** Resident #4 - No documentation service plan was reviewed and/or updated following readmission on 10/16/24. Service plan was updated on 12/10/24.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** When a resident is re-admitted to the community after an absence, a comprehensive assessment is completed by the DON or Community RN. The assessment will be recorded in the electronic record. If a licensed nurse is not in the facility upon a resident's return to the community, the on-call nurse will be contacted to receive the report. Any care changes needed will be added to the Service Plan via an ISP, reflecting the changes needed. The assessment will be completed the next day when a nurse is in the community. The DON will audit the need for comprehensive assessments daily through the 24-72 hour report. The DON will in-service the Community Nurse on this process.	07/31/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (b)(1)(B) Services. The assisted living facility shall provide the following: Three meals daily, seven days a week, including modified diets and snacks which have been evaluated and approved by a dietitian on a semi-annual basis and are appropriate to residents' needs and choices; **FINDINGS** No documented evidence that menus were evaluated and approved by the dietitian on a semi-annual basis.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, this deficiency has been corrected. The Chef has worked with the RD to obtain the appropriate documentation moving forward. A collection of snacks and other items for modified diets will be on hand for residents to have.	7/18/2025

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☒	§11-90-8 Range of services. (b)(1)(B) Services. The assisted living facility shall provide the following: Three meals daily, seven days a week, including modified diets and snacks which have been evaluated and approved by a dietitian on a semi-annual basis and are appropriate to residents' needs and choices; **FINDINGS** No documented evidence that menus were evaluated and approved by the dietitian on a semi-annual basis.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** At the start of each 8 week menu cycle, the Executive Chef will email the menu to the RD to review, print, sign and mail back the approved Menu with a wet signature via snail mail. The Executive Chef has been trained by the RD and has set up a tool on her calendar to ensure compliance is met by the state.	07/31/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (b)(1)(F) Services. The assisted living facility shall provide the following: Nursing assessment, health monitoring, and routine nursing tasks, including those which may be delegated to unlicensed assistive personnel by a currently licensed registered nurse under the provisions of the state Board of Nursing; **FINDINGS** Resident #1 – Health monitoring was not evident, as three kitchen staff members were not aware of resident's special diet, 1800 diabetic diet. Resident has Type II diabetes and is taking insulin. One staff member stated resident "eats whatever she wants."	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, deficiency was corrected. Director of Nursing submitted new diet order to the kitchen [1800 ADA] and notified the Dietary Manager that resident diet order was changed. Provided the Executive Chef with 1800 ADA diet information for his staff On 9/20/2024. The Director of Nurses added 1800 ADA diet information to the service plan, 1800 ADA education was also provided to the resident at that time.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (b)(1)(F) Services. The assisted living facility shall provide the following: Nursing assessment, health monitoring, and routine nursing tasks, including those which may be delegated to unlicensed assistive personnel by a currently licensed registered nurse under the provisions of the state Board of Nursing; **FINDINGS** Resident #1 – Health monitoring was not evident, as three kitchen staff members were not aware of resident's special diet, 1800 diabetic diet. Resident has Type II diabetes and is taking insulin. One staff member stated resident "eats whatever she wants."	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Any special diet order will be entered into PCC by the Resident Care Coordinator [RCC] and/or the Community Nurse [CRN]. RCC or CRN will notify the dietary staff, including Dietary Manager, in writing. Director of Nursing will coordinate with Dietary Manager to provide in-service to dietary staff on special diet. Educational material will be provided to resident. Intermittent Service Plan will be initiated for change in diet; resident will be monitored for 72 hours per Regency policy. Any concerns voiced by resident and/or staff will be addressed and additional education provided as needed.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (b)(1)(F) Services. The assisted living facility shall provide the following: Nursing assessment, health monitoring, and routine nursing tasks, including those which may be delegated to unlicensed assistive personnel by a currently licensed registered nurse under the provisions of the state Board of Nursing; **FINDINGS** Resident #2 – No documentation the facility performed health monitoring for the following incidents: • swollen leg and rash on chest documented in progress notes on 2/26/25. • L buttock skin breakdown documented in progress notes on 12/15/24.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (b)(1)(F) Services. The assisted living facility shall provide the following: Nursing assessment, health monitoring, and routine nursing tasks, including those which may be delegated to unlicensed assistive personnel by a currently licensed registered nurse under the provisions of the state Board of Nursing; **FINDINGS** Resident #2 – No documentation the facility performed health monitoring for the following incidents: • swollen leg and rash on chest documented in progress notes on 2/26/25. • L buttock skin breakdown documented in progress notes on 12/15/24.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Any new skin issue will be initially documented as a separate incident report followed by an intermittent service plan [ISP]. Resident will be monitored for at least 72 hours per Regency policy. The Director of Nursing will review 24-hour report and incident reports daily to ensure compliance. Community Nurse and/or RCC will monitor ISP's daily for accuracy and completeness. Community Nurse, RCC and Med Tech's will be in-serviced on this process.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (b)(1)(F) Services. The assisted living facility shall provide the following: Nursing assessment, health monitoring, and routine nursing tasks, including those which may be delegated to unlicensed assistive personnel by a currently licensed registered nurse under the provisions of the state Board of Nursing; **FINDINGS** The narcotic binder located in the nursing station med cart A shows narcotic counts between two (2) staff were not completed on multiple occasions for the month of April 2025.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (b)(1)(F) Services. The assisted living facility shall provide the following: Nursing assessment, health monitoring, and routine nursing tasks, including those which may be delegated to unlicensed assistive personnel by a currently licensed registered nurse under the provisions of the state Board of Nursing; **FINDINGS** The narcotic binder located in the nursing station med cart A shows narcotic counts between two (2) staff were not completed on multiple occasions for the month of April 2025.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** The community RN will conduct weekly audits of the narcotic log to ensure accuracy and completeness. These audits will be documented and kept in a binder in the Wellness Office for 90 days. Any discrepancies will be reported to the Director of Nursing and addressed immediately. Director of Nursing will complete in-service on this process for the Community Nurse and Resident Care Coordinator. Director of Nursing and Pharmacy Representative will complete education and training for all Med Techs at the July Wellness Meeting.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-9 Record and reports system. (a)(1) The facility shall establish policies and procedures to maintain a system of records and reports which shall include the following: Copy of a current physician or primary care provider's report of resident's physical examination which includes tuberculosis clearance and verification that the resident is free from other infectious or contagious diseases; **FINDINGS** Resident #5, #6, #7, and #8 – No documented evidence of current physical examination (PE). *Submit a copy with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, this deficiency was corrected. Resident #5 – Received H&P from PCP (see attached). Resident #8 – Have current physical for 2025 from KCH (see attached). Resident #6 – Resident PCP has left her medical practice. Resident has established care with new provider. New PCP has done initial physical exam and I have requested a copy. Once received I will scan it into the resident's electronic record. Resident #7 – Have requested current H&P 3 times via fax, once via voicemail message. No response. Will continue to contact PCP and will solicit resident assistance.	7/18/2025

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☒	§11-90-9 Record and reports system. (a)(1) The facility shall establish policies and procedures to maintain a system of records and reports which shall include the following: Copy of a current physician or primary care provider's report of resident's physical examination which includes tuberculosis clearance and verification that the resident is free from other infectious or contagious diseases; **FINDINGS** Resident #5, #6, #7, and #8 - No documented evidence of current physical examination (PE).	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** A better Process has been developed: Resident Care Coordinator will monitor due dates for physician visits in PCC and notify physician via fax of need for copy of current physical exam. If documentation is not received within 7 days, Resident Care Coordinator will fax the office a second time and then a third. If documentation is not received within 7 days of 3rd notification, Director of Nursing will be notified. Director of Nursing will then place phone call directly to provider office. Director of Nursing and/or Community RN will continue to contact provider until information received. This will then be scanned into resident electronic	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-9 Record and reports system. (a)(1) The facility shall establish policies and procedures to maintain a system of records and reports which shall include the following: Copy of a current physician or primary care provider's report of resident's physical examination which includes tuberculosis clearance and verification that the resident is free from other infectious or contagious diseases; **FINDINGS** Resident #8, and #9 - No documented evidence of initial tuberculosis (TB) clearance signed by a practitioner (as required by Hawaii TB rules). *Submit a copy with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, this deficiency has been corrected. Director of Nursing met with Nurse Practitioner; TB Clearance form was completed and signed by Nurse Practitioner. Please see the attached for Resident #8 and #9.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-9 Record and reports system. (a)(1) The facility shall establish policies and procedures to maintain a system of records and reports which shall include the following: Copy of a current physician or primary care provider's report of resident's physical examination which includes tuberculosis clearance and verification that the resident is free from other infectious or contagious diseases; **FINDINGS** Resident #8 and #9 - No documented evidence of initial tuberculosis (TB) clearance signed by a practitioner (as required by Hawaii TB rules).	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Director of Nursing or Designee will obtain a copy of initial TB test prior to admission to facility. TB Clearance form will be completed and attached. Forms will be placed in file folder and the Resident Care Coordinator will notify the nurse practitioner [before the end of each month] that TB Clearance forms are ready to be signed. Once they are signed, Resident Care Coordinator will scan them into the electronic record. Director of Nurses will in-service Community Nurse and Resident Care Coordinator on this process.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-9 Record and reports system. (a)(1) The facility shall establish policies and procedures to maintain a system of records and reports which shall include the following: Copy of a current physician or primary care provider's report of resident's physical examination which includes tuberculosis clearance and verification that the resident is free from other infectious or contagious diseases; **FINDINGS** Resident #4, #5, and #10 - No documented evidence of current TB clearance signed by a practitioner (as required by Hawaii TB Rules). *Submit a copy of the documentation with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, this deficiency was corrected. The Director of Nursing met with the Nurse Practitioner. TB Clearance form was completed and signed by Nurse Practitioner for Resident #4, 5,and 10 (see attached).	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-9 Record and reports system. (a)(1) The facility shall establish policies and procedures to maintain a system of records and reports which shall include the following: Copy of a current physician or primary care provider's report of resident's physical examination which includes tuberculosis clearance and verification that the resident is free from other infectious or contagious diseases; **FINDINGS** Resident #4, #5, and #10 - No documented evidence of current TB clearance signed by a practitioner (as required by Hawaii TB Rules).	**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 Care Coordinator will monitor dates of annual TB tests in PCC and provide a list to the Community Nurse at the beginning of each month. Community Nurse will complete individual TB tests or screenings and document information on appropriate forms. TB Clearance form will be completed and attached. Forms will be placed in file folder and the Resident Care Coordinator will notify the nurse practitioner [before the end of each month] that TB Clearance forms are ready to be signed. Once they are signed, Resident Care Coordinator will scan them into the electronic record. Director of Nurses will in-service Community Nurse and Resident Care Coordinator on this process.	7/18/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-9 Record and reports system. (a)(4) The facility shall establish policies and procedures to maintain a system of records and reports which shall include the following: Incident reports of any bodily injury or other unusual circumstances affecting a resident which occurs within the facility, on the premises, or elsewhere, shall be retained by the facility under separate cover, and be available to authorized personnel and the department. The resident's physician or primary care provider shall be called immediately if medical care is necessary or indicated. **FINDINGS** Resident #2 – No incident report was generated for swollen leg and rash on chest documented on progress notes on 2/26/25.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-9 Record and reports system. (a)(4) The facility shall establish policies and procedures to maintain a system of records and reports which shall include the following: Incident reports of any bodily injury or other unusual circumstances affecting a resident which occurs within the facility, on the premises, or elsewhere, shall be retained by the facility under separate cover, and be available to authorized personnel and the department. The resident's physician or primary care provider shall be called immediately if medical care is necessary or indicated. **FINDINGS** Resident #2 – No incident report was generated for swollen leg and rash on chest documented on progress notes on 2/26/25.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** The Community Nurse, Resident Care Coordinator and Med Techs will be in-serviced on this process. In-service will include when to initiate an incident report and the documentation required to be completed. The Director of Nursing will monitor the 24-72 hour report for any change of condition/unusual incident. Any identified issues will be corrected and education provided as needed.	7/18/2025

Licensee's/Administrator's Signature: R Stouder

Print Name: Robin Stouder

Date: 07/02/2025

Licensee's/Administrator's Signature: _____

Print Name: Robin Stouder

Date: 07/31/2025