

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: De Rego Care Home	CHAPTER 100.1
Address: 224 Lanialii Street, Wahiawa, Hawaii 96786	Inspection Date: December 12, 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
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. FINDINGS Resident #1 – Physician ordered “Acetaminophen 500mg tablet, take 1 tablet by mouth every 6 hours as needed for pain” on 12/8/2024. Medications not available in facility for resident use.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY PCG went to the pharmacy and purchased the medication. Sticky note with Physician's medication instructions was attached to the bottle.	1/15/25 25 SEP 2025 11:12

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. FINDINGS Resident #1 – Physician ordered “Acetaminophen 500mg tablet, take 1 tablet by mouth every 6 hours as needed for pain” on 12/8/2024. Medications not available in facility for resident use.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? PCG will set a calendar reminder to review all resident's medication lists weekly and verify that all medications are filled and available for the resident's use. If any medications are low or out, the PCG will order a refill from the pharmacy.	25 SEP 2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (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. <u>FINDINGS</u> Resident #1 – Physician ordered “Metoprolol succinate 25mg tablet, take 1 tablet by mouth daily for 30 days” and “Acetaminophen 500mg tablet, take 1 tablet by mouth every 6 hours as needed for pain” on 12/8/2024. Medications not documented on December 2024 medication administration record (MAR).	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY PCG added the medications into the December MAR and updated the times that the medications were given going forward.	12/23/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (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. <u>FINDINGS</u> Resident #1 – Physician ordered “Metoprolol succinate 25mg tablet, take 1 tablet by mouth daily for 30 days” and “Acetaminophen 500mg tablet, take 1 tablet by mouth every 6 hours as needed for pain” on 12/8/2024. Medications not documented on December 2024 MAR.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? PCG will set a calendar reminder to verify weekly that all medications that the residents have been prescribed are being documented by staff at the time they are administered to the resident.	75 SEP 25 13

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications. FINDINGS Bedroom #1 – Observed a medication cup with a single white pill on resident's bedside table unsecured.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY Removed the medication cup from the Resident's room and disposed of the white pill.	12/12/24 75 SEP 01 11:13

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1.1-15 Medications. (1) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications. FINDINGS Bedroom #1 – Observed a medication cup with a single white pill on resident's bedside table unsecured.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? Care home staff will observe each resident while taking their medications and ensure that no medications are left unsecured. Care home staff will set a daily phone alarm for 8 PM to check each resident bedroom to ensure there are no unsecured medications.	75 SEP 21 10:11 3

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications</u>. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #1 – Physician ordered “Acetaminophen 325mg,” Ammonium lactate topical lotion,” “Cyanocobalamin 1000mcg,” “Ergocalciferol,” “Polyethylene glycol 3350 17gm,” “Pravastatin 40mg,” “Quetiapine 25mg,” and “Trazodone 12mg” on 11/3/2024. Primary Care Giver (PCG) stated medications were discontinued by the physician on 12/8/2024 during Emergency Room (ER) visit. The aforementioned medications were indicated on the December 2024 MAR was as given on 12/9/2024-12/11/2024.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	25 SEP 2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications. (m)</u> All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #1 – Physician ordered “Acetaminophen 325mg,” Ammonium lactate topical lotion,” “Cyanocobalamin 1000mcg,” “Ergocalciferol,” “Polyethylene glycol 3350 17gm,” “Pravastatin 40mg,” “Quetiapine 25mg,” and “Trazodone 12mg” on 11/3/2024. Primary Care Giver (PCG) stated medications were discontinued by the physician on 12/8/2024 during Emergency Room (ER) visit. The aforementioned medications were indicated on the December 2024 MAR was as given on 12/9/2024-12/11/2024.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? As soon as a De Rego Care home staff member receives new medication orders for one of our residents, the MAR will be updated by the end of the day, and any medication that has been discontinued will be disposed of. PCG will set a calendar reminder to verify weekly that the MAR reflects the current orders from the resident's PCP.	12/11/2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications. (m)</u> All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #1 – Physician ordered “Metoprolol succinate 25mg tablet, take 1 tablet by mouth daily for 30 days” on 12/8/2024. No documented evidence if medication was either given to, refused by, or held from the resident from 12/8/2024 to present.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	25 SEP 2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications</u>. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. FINDINGS Resident #1 – Physician ordered “Metoprolol succinate 25mg tablet, take 1 tablet by mouth daily for 30 days” on 12/8/2024. No documented evidence if medication was either given to, refused by, or held from the resident from 12/8/2024 to present.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? As soon as a De Rego Care home staff member receives new medication orders for one of our residents, the MAR will be updated by the end of the day. PCG will set a calendar reminder to verify weekly that the MAR reflects the current orders from the resident's PCP and that it is notated whenever a staff member administers the medication to the resident.	25 SEP 2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; FINDINGS Resident #1 – No documented evidence of current annual tuberculosis clearance by a physician or advanced practice registered nurse (APRN) on file.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY Resident was discharged from De Rego Care Home before the correction could be made.	09/01/25 25 SEP 2025

Completion Date	PLAN OF CORRECTION	Completion Date
☒	RULES (CRITERIA) §11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; <u>FINDINGS</u> Resident #1 – No documented evidence of current annual tuberculosis clearance by a physician or APRN on file. PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? PCG will use the Admission checklist to ensure that all new resident's documents are obtained before admission. PCG will set a monthly calendar reminder to check each resident's file to ensure that the documents are on file and current.	25 SEP 2017 10:11:12

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports: (b)(3) During residence, records shall include: 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; <u>FINDINGS</u> Resident #1 – No documented evidence of progress notes regarding resident's response to medications, diet, activities and treatments for November 2024.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	25 SEP 2024

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include: 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; <u>FINDINGS</u> Resident #1 – No documented evidence of progress notes regarding resident's response to medications, diet, activities and treatments for November 2024.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? PCG will set a monthly calendar reminder to review each resident's progress notes and ensure that De Rego care home staff are documenting the resident progress at very least monthly.	25 SEP 24

Completion Date	PLAN OF CORRECTION	RULES (CRITERIA)
25 SEP 2024	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY PCG completed and filed an incident report for Resident #1's emergency room visit on 12/08/24 and filed it in her file.	☒ §11-100.1-17 Records and reports. (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary. FINDINGS Resident #1 – No documented evidence of an incident report for emergency room visit on 12/8/2024.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary. FINDINGS Resident #1 – No documented evidence of an incident report for emergency room visit on 12/8/2024.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? Whenever there is an incident that need to be documented, De Rego Care Home staff will complete an incident report and file it in the resident's file. PCG will set a monthly calendar reminder to check each resident's file to ensure that every incident report has been saved in the resident's file.	23 SEP 24 11:13

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (e) In the event of an emergency, an oral summary of the resident's condition shall be provided to the receiving facility, followed by a written transfer summary. FINDINGS Resident #1, Resident #2 – No documented evidence of a resident emergency information sheet on file for department review.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY Printed and filled out a Resident emergency information sheet for each resident and attached the latest PCP appointment after visit summary. Placed in the med lock up cabinet ready for department review or first responder review.	9/15/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (e) In the event of an emergency, an oral summary of the resident's condition shall be provided to the receiving facility, followed by a written transfer summary. FINDINGS Resident #1, Resident #2 – No documented evidence of a resident emergency information sheet on file for department review.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? A Resident emergency information sheet for each resident will be filled out and attached with the latest PCP appointment after visit summary. The documents will be placed in the med lock up cabinet ready for department review or first responder review. The PCG will set a calendar reminder to check the med lock up cabinet monthly to ensure that each resident has the Emergency information sheet on file for each resident.	25 SEP 2019

Completion Date	PLAN OF CORRECTION	RULES (CRITERIA)
09/10/25 75 SEP 10 2025	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY Inventoried the belongings for Resident #2 and Resident #3, then filled out the form to add to their files.	☒ §11-100.1-19 Resident accounts. (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. <u>FINDINGS</u> Resident #2, Resident #3 – No documented evidence of a current annual inventory of belongings on file.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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. FINDINGS Resident #2, Resident #3 – No documented evidence of a current annual inventory of belongings on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? PCG will set a monthly calendar reminder to check each resident's file to ensure that a current belongings inventory form is on file.	25 SEP 2019

Devan De Rego, PCG

Licensee's/Administrator's Signature:

Print Name: Devan De Rego, PCG

Date: Sep 22, 2025

25 SEP 2025 11:13

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