

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Erlita Magdirila Care Home	CHAPTER 100.1
Address: 94-418 Loaa Street, Waipahu, Hawaii 96797	Inspection Date: January 15, 2026 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).

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>, (b)(1)(I) Application.</p> <p>In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application:</p> <p>Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law;</p> <p><u>FINDINGS</u> SCG #1 – Two consecutive years of Fieldprint clearance unavailable. Only 1/9/25 clearance unavailable; however, employee started on 3/12/24 per SCG training log</p> <p>Submit a copy of Fieldprint clearance for 2026 with plan of correction.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Fieldprint clearance for SCG #1 was completed on 1/29/26 and documentation was placed in the resident binder.</p>	<p>01/29/2026</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>. (b)(1)(1) Application.</p> <p>In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application:</p> <p>Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law;</p> <p><u>FINDINGS</u> Substitute Caregiver (SCG) #1 – Two consecutive years of Fieldprint clearance unavailable. Only 1/9/25 clearance unavailable; however, employee started on 3/12/24 per SCG training log</p> <p>Submit a copy of Fieldprint clearance for 2026 with plan of correction.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Fieldprint clearance for SCG #1 was completed on 1/29/26 and documentation was placed in the resident binder.</p> <p>I made a check list for completion of requirements for PCG and SCGs. This checklist in tabulation form is named PCG/SCG REQUIREMENTS. It shows the names of PCG/SCG's fingerprints and dates taken. This will be placed on the ARCH binder. I will refer to this checklist as a reminder to update the documents.</p>	03/03/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-8 <u>Primary care giver qualifications.</u> (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall:</p> <p>Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current;</p> <p><u>FINDINGS</u> Primary Caregiver (PCG) – Only five (5) of six (6) annual continuing education hours completed</p> <p>Submit evidence of one (1) hour of completed continuing education with plan of correction.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Additional of 1.5 education hours was completed on 1/22/26 and documentation was placed in the ARCH binder to complete the required CEU.</p>	<p>01/22/2026</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-8 <u>Primary care giver qualifications.</u> (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall:</p> <p>Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current;</p> <p><u>FINDINGS</u> Primary Caregiver (PCG) – Only five (5) of six (6) annual continuing education hours completed</p> <p>Submit evidence of one (1) hour of completed continuing education with plan of correction.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Additional of 1.5 education hours was completed on 1/22/26 and documentation was placed in the ARCH binder to complete the required CEU.</p> <p>I made a check list for completion of requirements for PCG and SCGs. This checklist in tabulation form is named PCG/SCG REQUIREMENTS. It shows the names of PCG/SCG's TRAININGS and dates taken. This will be placed on the ARCH binder. I will refer to this checklist as a reminder to update the documents.</p>	<p style="text-align: center;">03/03/26</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p>FINDINGS SCG #2 – Initial TB clearance unavailable</p> <p>Submit a copy with plan of correction.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Chest X-ray and TB testing were done for SCG #2 on 1/26/26 showing no evidence of active pulmonary TB signed and dated by doctor and documentation was placed in the resident binder.</p>	01/26/2026

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance.</p> <p><u>FINDINGS</u> SCG #2 – Initial TB clearance unavailable</p> <p>Submit a copy with plan of correction.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Chest X-ray was done on 1/26/2026 and no evidence of active pulmonary TB signed and dated by doctor and documentation was placed in the resident binder.</p> <p>TB testing was done on 11/20/2018 showed positive TB result. TB screening form was filled up 01/17/2025 with no evidence of active pulmonary TB signed and dated by doctor and documentation was placed in the resident binder.</p> <p>I made a check list for completion of requirements for PCG and SCGs. This checklist in tabulation form is named PCG/SCG REQUIREMENTS. It shows the names of PCG/SCG's TB tests and dates taken. This will be placed on the ARCH binder. I will refer to this checklist as a reminder to update the documents.</p>	03/03/26

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	<p>§11-100.1-15 <u>Medications</u>, (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Physician’s order dated 2/27/25 states, “Miralex Mix 1 capful in 6oz of fluid. Clean out: Drink three times per day until stools are watery-clear. Usually takes 2-3 days. Then start maintenance: 1 ap once per day to keep stools applesauce consistency; may titrate to achieve right consistency. If too watery, give ½ dose the next day. If too hard, give dose 2x the next day.”; however, per MAR shows medication being administered as “Miralex 1 capful by mouth daily to keep stools apple cause consistency”; titration order is not being made available and dosage administered is not being documented</p> <p>Submit a copy of revised medication administration record (MAR) with plan of correction.</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>The order for Miralex titration given on 2/27/25 by the PCP was written in the MAR and placed in the client’s binder.</p>	<p>01/27/2026</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>, (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Physician’s order dated 2/27/25 states, “Miralax Mix 1 capful in 6oz of fluid. Clean out: Drink three times per day until stools are watery-clear. Usually takes 2-3 days. Then start maintenance: 1 ap once per day to keep stools applesauce consistency; may titrate to achieve right consistency. If too watery, give ½ dose the next day. If too hard, give dose 2x the next day.”; however, per MAR shows medication being administered as “Miralax 1 capful by mouth daily to keep stools apple cause consistency”; titration order is not being made available and dosage administered is not being documented</p> <p>Submit a copy of revised medication administration record (MAR) with plan of correction.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>The order for Miralax titration given on 2/27/25 by the PCP was written in the MAR and placed in the client's binder.</p> <p>In the future, to prevent this deficiency, all doctors orders and medications written in the MAR will be reviewed and double checked by another staff to be signed and dated. In service about the right documentation of medication and counter signing of another staff in the MAR was done with another SCG.</p>	<p>03/03/26</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year.</p> <p><u>FINDINGS</u> Resident #1 – No documented evidence medications were reevaluated and signed by physician every 4 months since 1/29/25</p> <p>Submit a copy of reevaluated and signed medication orders with plan of correction.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>A copy of updated medication list was signed by the physician on 1/27/26 and placed in the client's binder.</p>	<p>01/27/2026</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year.</p> <p><u>FINDINGS</u> Resident #1 – No documented evidence medications were reevaluated and signed by physician every 4 months since 1/29/25</p> <p>Submit a copy of reevaluated and signed medication orders with plan of correction.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>A copy of updated medication list was signed by the physician on 1/27/26 and placed in the client's binder.</p> <p>I made a check list for completion of requirements for clients. This checklist is named DOCUMENTS REQUIREMENTS FOR CLIENTS. It includes Medication list evaluation and dates every four months. This checklist will be placed on the Client's chart and I will refer to this checklist as a reminder.</p>	03/03/26

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-16 <u>Personal care services.</u> (i) The primary care giver shall provide the opportunity for each resident to have pneumococcal and influenza vaccines and all necessary immunizations following the recommendations of the Advisory Committee on Immunization Practices (ACIP) or resident's physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Evidence of current influenza vaccination unavailable</p> <p>Submit a copy with plan of correction.</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>A documentation showing that refused flu vaccine as per family request was obtained from PCP dated and signed 1/27/26 and placed in the client's binder.</p>	<p>01/27/2026</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-16 <u>Personal care services.</u> (i) The primary care giver shall provide the opportunity for each resident to have pneumococcal and influenza vaccines and all necessary immunizations following the recommendations of the Advisory Committee on Immunization Practices (ACIP) or resident's physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – Evidence of current influenza vaccination unavailable</p> <p>Submit a copy with plan of correction.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>A documentation showing that refused flu vaccine as per family request was obtained from PCP dated and signed 1/27/26 and placed in the client's binder.</p> <p>I made a check list for completion of requirements for clients. This checklist is named DOCUMENTS REQUIREMENTS FOR CLIENTS. It includes Flu vaccine and dates every year. This checklist will be placed on the Client's chart and I will refer to this checklist as a reminder.</p>	03/03/26

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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> (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;</p> <p><u>FINDINGS</u> Resident #1,2 – Initial TB clearance unavailable</p> <p>Submit a copy with plan of correction.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Initial TB test was obtained on 1/26/26 for resident #1 and placed in the client's binder. Step 2 TB test was obtained on 1/26/26 for resident #2 and placed in the client's binder.</p>	<p>01/26/2026</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> (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies;</p> <p><u>FINDINGS</u> Resident #1,2 – Initial TB clearance unavailable</p> <p>Submit a copy with plan of correction.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Initial TB test was obtained on 1/26/26 for resident #1 and placed in the client's binder. Step 2 TB test was obtained on 1/26/26 for resident #2 and placed in the client's binder.</p> <p>I made a check list for completion of requirements for clients. This checklist is named DOCUMENTS REQUIREMENTS FOR CLIENTS. It includes TB testing and dates every year. This checklist will be placed on the Client's chart and I will refer to this checklist as a reminder.</p>	<p>03/03/26</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>, (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><u>FINDINGS</u> Resident #1 – Current annual TB clearances unavailable</p> <p>Submit a copy with plan of correction.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Step 2 TB testing is scheduled on 2/2/26 to complete the requirements for TB clearance.</p>	02/02/2026

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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><u>FINDINGS</u> Resident #1 – Current annual TB clearances unavailable</p> <p>Submit a copy with plan of correction.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Step 2 TB testing is scheduled on 2/2/26 to complete the requirements for TB clearance.</p> <p>I made a check list for completion of requirements for clients. This checklist is named DOCUMENTS REQUIREMENTS FOR CLIENTS. It includes TB testing and dates every year. This checklist will be placed on the Client's chart and I will refer to this checklist as a reminder.</p>	03/03/26

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<input checked="" type="checkbox"/>	<p>§11-100.1-20 <u>Resident health care standards.</u> (e) Arrangements shall be made by the primary care giver for annual dental examinations. Arrangements shall be made by the primary or substitute care giver for emergency dental examinations.</p> <p><u>FINDINGS</u> Resident #1 – Current annual dental exam unavailable</p> <p>Submit a copy with plan of correction.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Obtained the current copy of dental visit Clinical Notes on 1/28/26 and placed in the client's binder.</p>	<p>01/28/2026</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-20 <u>Resident health care standards.</u> (e) Arrangements shall be made by the primary care giver for annual dental examinations. Arrangements shall be made by the primary or substitute care giver for emergency dental examinations.</p> <p><u>FINDINGS</u> Resident #1 – Current annual dental exam unavailable</p> <p>Submit a copy with plan of correction.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>Obtained the current copy of dental visit Clinical Notes on 1/28/26 and placed in the client's binder.</p> <p>I made a check list for completion of requirements for clients. This checklist is named DOCUMENTS REQUIREMENTS FOR CLIENTS. It includes Dental visit records and dates every year. This checklist will be placed on the Client's chart and I will refer to this checklist as a reminder.</p> <p>NOTE: ALL REQUIRED COPIES FOR THIS POC WILL BE SENT IN YOUR EMAIL.</p>	<p>03/03/26</p>

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<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment</u>, (g)(3)(D) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>A drill shall be held to provide training for residents and personnel at various times of the day or night at least four times a year and at least three months from the previous drill, and the record shall contain the date, hour, personnel participating and description of drill, and the time taken to safely evacuate residents from the building. A copy of the fire drill procedure and results shall be submitted to the fire inspector or department upon request;</p> <p><u>FINDINGS</u> No documented evidence any monthly fire drill between 1/2025-12/2025 was conducted during hours of darkness</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(D) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>A drill shall be held to provide training for residents and personnel at various times of the day or night at least four times a year and at least three months from the previous drill, and the record shall contain the date, hour, personnel participating and description of drill, and the time taken to safely evacuate residents from the building. A copy of the fire drill procedure and results shall be submitted to the fire inspector or department upon request;</p> <p><u>FINDINGS</u> No documented evidence any monthly fire drill between 1/2025-12/2025 was conducted during hours of darkness</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>A Fire drill schedule form was made indicating different times of the day to perform fire drills quarterly. This form was placed on the binder.</p>	<p>02/01/2026</p>

Licensee's/Administrator's Signature: erlita magdirila

Print Name: erlita magdirila

Date: 01/31/2026

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Licensee's/Administrator's Signature: erlita magdirila

Print Name: erlita magdirila

Date: 03/03/26

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