

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Felarca Care Home	CHAPTER 100.1
Address: 4679 Likini Street, Honolulu, Hawaii 96818	Inspection Date: July 9, 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 PER HAR 11-100.1-3(e)(2). IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

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

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (c)            Separate compartments shall be provided for each resident's medication and they shall be segregated according to external or internal use.</p> <p><b><u>FINDINGS</u></b>            Resident #1 – Observed topical “Nystatin powder” mixed with other oral medications in residents’ medication bin. Aforementioned medication not segregated by external and internal use.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>Placed prescribed powder medication into a sealable bag, zip-Lock, with proper labeling to indicate that medication is meant for external use and not to be confused as an internal or consumable drug via mouth or rectal route(s).</p> <p style="text-align: right;"><i>DUF</i></p>	<p>11/30/2025</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 Medications. (c) Separate compartments shall be provided for each resident's medication and they shall be segregated according to external or internal use.</p> <p><b><u>FINDINGS</u></b> Resident #1 – Observed topical “Nystatin powder” mixed with other oral medications in residents’ medication bin. Aforementioned medication not segregated by external and internal use.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>Once a week, a mock review of medications will be performed for all internal and external medication's for proper segregation, this will familiarize all backup caregivers with residents medications and how they must be stored and segregated and if need be corrected. This will be documented by all CG's in their residents progress notes. During monthly visit with the case managers for the residents at the ARCH, both MAR and medication bins will be made available to RN to visually inspect contents for proper storage, segregation, and availability. Visits are marked on ARCH calendars in hard copy and digital and will count as mandatory review of medications to remain compliant with DOH. Case managers will also be asked to notate that they had reviewed MAR and medication in locked storage, medication segregation and medication availability. All checks will be documented in PCG and CHO Resident Progress Notes.</p> <p style="text-align: right;"><i>DA</i></p>	<p style="text-align: center;">1/10/2026</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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><b><u>FINDINGS</u></b> Resident #1 – “Bisacodyl 10mg rectal supp,” “Sennosides/docusate sodium 8.6/50mg tablet,” “Lidocaine 5% ointment,” “Guaifenesin 100mg/5mL liquid,” and “Dextromethorphan-guaifenesin 60-1200mg tab” not available in the facility for resident use.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>Called prescriber(s) of missing medication(s) and confirmed that medication was on the active use routine or PRN (As Needed). Once drug was confirmed to be active for resident, confirmed dosage, route of delivery, time of delivery of medication, example; internal use or external use. Confirmed if medication has sufficient refills, if not a new prescription is ordered from prescriber to pharmacy with sufficient refills till next visit of prescriber. Lastly asked prescriber to label the reason of use for medication so that when pharmacy prints label for the medication(s), it will clearly state on pharmacy label.</p> <p>Called pharmacy to confirm new prescription order(s) for resident, or refill medication if valid refills remaining. Reminded pharmacy to clearly label drug order(s) and clearly state directions of use of medication(s) and state use of medication(s) is visible on label.</p>	<p>11/30/2025</p> <p style="text-align: right;">DJA</p>

RECEIVED

JAN 16 2026

	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><b><u>FINDINGS</u></b> Resident #1 – “Bisacodyl 10mg rectal supp,” “Sennosides/docusate sodium 8.6/50mg tablet,” “Lidocaine 5% ointment,” “Guaifenesin 100mg/5mL liquid,” and “Dextromethorphan-guaifenesin 60-1200mg tab” not available in the facility for resident use.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future, bi-weekly / monthly checks with Primary Care Giver (PCG) and backup caregiver (CG). Will be performed to confirm if medication is sufficient for resident(s) needs. Will also train caregivers of best practices of medication(s) practices for ARCH (Adult Residential Care Home) residents.</p>	<p>11/30/2025</p> <p style="text-align: right;">DUF</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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><b><u>FINDINGS</u></b> Resident #1 – No medication administration records (MARs) from August 2024 to June 2025 on file for department review.</p>	<p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	

RECEIVED  
JAN 16 2026

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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><b><u>FINDINGS</u></b> Resident #1 – No MARs from August 2024 to June 2025 on file for department review.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future, back up caregivers will be taught how to properly read and document on MAR. This includes proper medication, delivery of medication, time of medication, route of medication and how to document if resident does not want to take medication. This will also reflect on progress notes of resident that a review of MAR at the beginning of the month and end of the month.</p> <p>The MAR will be used whenever medication is delivered to resident and reviewed EVERY evening so that MAR has been correctly documented, corrected if need be. MAR's will be reviewed by Nurse Case Manager of resident on a monthly basis. Review of MAR will be documented on calendar, both digital and hardcopy. Case managers will note that they did review resident MAR during their monthly visit a nurse assessment log. For residence without a Nurse Case Manager PCG and CHO will review residence MAR once a month for daily compliance of MAR documentation.</p>	<p>1/10/2026</p> <p style="text-align: right;"><i>DLF</i></p>



	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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><b><u>FINDINGS</u></b> Resident #1 – Physician ordered “Melatonin 1mg tab, take 3 tablets by mouth at bedtime.” July MAR reads “Melatonin 1mg tab, take 1 tablet by mouth at bedtime.” Entry and medication label does not match.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future, during monthly visits by nurse case manager, for resident(s) who are Expanded ARCH (E-ARCH) residents, will have MAR list reviewed for accuracy to validate concise information from prescriber(s) order(s) to reflect on MAR and proper instructions and labeling on pharmacy labels. For residents who are not E-ARCH, 2 (two) caregivers will review MAR, prescriber(s) order(s) and pharmacy label for clear and concise order(s). If order(s) are unclear, will call prescriber(s) to revise label(s) to properly state order(s) and have pharmacy reprint label to reflect any change(s).</p>	<p>11/30/2025</p> <p style="text-align: right;">DUF</p>

RECEIVED  
JAN 16 2026





RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-15 Medications. (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.  <b>FINDINGS</b> Resident #1 – Observed the following expired medications in residents’ medication bin: “Bisacodyl 10mg rectal supp,” “Sennosides/docusate sodium 8.6/50mg tablet,” and “Lidocaine 5% ointment.”	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>Confirmed with provider of medications were on the active medication list for resident. Providers office confirmed medication list and stated that lidocaine 5% ointment was D/C'd. In the future, carehome shall check medications weekly between CHO and PCG to active medication list. Medications will be segregated between For Internal Use, For External Use and For Rectal Use and be stored in separate bins in separate locked medication lockers. Internal ingestible use medications will be stored in separate resident bins from external use (example, topical creams and topical ointments) medication and sealed in a reusable plastic bag separate from P.O. meds. Medications given rectally will also be separated from P.O. meds and external use medications and also be placed in a resealable bag in its own bin; in a locked medication locker.</p> <p>Medications will be reviewed with nurse case manager, if resident has a case manager, during their monthly visit. During case managers visit all bins will be checked by case manager for proper storage or proper segregation of medicines and will document on their monthly assessment that medication review had occurred and medications are properly stored.</p> <p>Care Home Operator (CHO) and Primary Care Giver (PCG) will train all caregivers the proper procedure for storage of medications and any special procedures in handling or administering medications to the resident.</p> <p>A quarterly calendar review of proper medication storage review will be followed quarterly and 45 day mandatory review of all resident medication prior to annual inspection of ARCH.</p>	<p style="text-align: center;">1/15/2026</p> <p style="text-align: right; font-size: 2em;">DVT</p>

RECEIVED

JAN 16 2026

	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
☒	<p>§11-100.1-15 <u>Medications.</u> (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.</p> <p><b><u>FINDINGS</u></b> Resident #1 – Observed the following expired medications in residents’ medication bin: “Bisacodyl 10mg rectal supp,” “Sennosides/docusate sodium 8.6/50mg tablet,” and “Lidocaine 5% ointment.”</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future, medication(s) expiration dates will be clearly displayed better on their bottles and all caregivers will review all medication(s) in their bin(s) to check for soon to be expire and low quantity medications by glancing at the bottle lids and alert the PCG and/or CHO of medications that require attention. As medication are dispensed daily a reminder and weekly review of remaining stocks will be logged as to when to refill active medications and a log of change orders or discontinued use of medication(s) and appropriate disposal of remaining stocks. Logging of medications or disposal of medications will be found on MAR.</p> <p>Said drugs will be flagged and appropriate action will be done to assure medication is available to resident. Medication disposal shall follow ARCH's best practices disposal guidelines in handling prescription returns to dispensing pharmacy or medical waste and the disposal of unused prescription drugs.</p>	<p style="text-align: center;">11/30/2025</p> <p style="text-align: right; font-size: 1.5em;">DUF</p>

RECEIVED

JAN 16 2026

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p><b><u>FINDINGS</u></b>  Resident #1 – No documented evidence that prescribed medications were either given to the resident, refused by the resident, or held from the resident from July 27, 2024 to July 7, 2025.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	

RECEIVED  
JAN 16 2026

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p><b><u>FINDINGS</u></b> Resident #1 – No documented evidence that prescribed medications were either given to the resident, refused by the resident, or held from the resident from July 27, 2024 to July 7, 2025.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future, back up caregivers will be taught how to properly read and document on MAR. This includes proper medication, delivery of medication, time of medication, route of medication and how to document if resident does not want to take medication. This will also reflect on progress notes of resident that a review of MAR at the beginning of the month and end of the month.</p> <p>The MAR will be used whenever medication is delivered to resident and reviewed EVERY evening so that MAR has been correctly documented, corrected if need be. MAR's will be reviewed by Nurse Case Manager of resident on a monthly basis. Review of MAR will be documented on calendar, both digital and hardcopy. Case managers will note that they did review resident MAR during their monthly visit a nurse assessment log. For residence without a Nurse Case Manager PCG and CHO will review residence MAR once a month for daily compliance of MAR documentation.</p>	<p>1/10/2026</p> <p style="text-align: right;"><i>DWJ</i></p>

RECEIVED

JAN 16 2026

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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><b><u>FINDINGS</u></b> Resident #1, Resident #2 – No documented evidence of progress notes for the past twelve (12) months on file for department review.</p>	<p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	

RECEIVED  
JAN 16 2026

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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><b><u>FINDINGS</u></b> Resident #1, Resident #2 – No documented evidence of progress notes for the past twelve (12) months on file for department review.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future, back up caregivers will be taught how to properly read and document on Progress Notes on both Progress Note Forms. Progress Note will reflect each resident. Progress notes to be filed from back-up caregivers will bi-monthly for all residents. PCG or CHO will file monthly Progress Notes reports for ARCH residents, and bi-monthly for E-ARCH residents. Progress notes will be reviewed 10 days after service month to ensure compliance with DOH rules and that all caregivers have sufficient time to update residents file. Full compliance checks on Progress Notes will be done every 3 months by CHO and PCG for compliance. Special review of Progress notes will be done 45 days to Annual Inspection. Such review dates will also be on ARCH calendars, both digital and hard copy so all caregivers can review Progress Notes and that they are properly completed. Progress Notes will be available to nurse case managers review if resident is an E-ARCH resident. Nurse case managers will be asked to mark in their monthly assessments that Progress Notes were reviewed in there monthly progress notes.</p>	<p>1/10/2026</p> <p style="text-align: right;">DUF</p>

RECEIVED

JAN 16 2026

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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><b>FINDINGS</b></u> Resident #3 – No documented evidence of progress notes from admission in February 2025 to June 2025 on file for department review.	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	

**RECEIVED**  
JAN 16 2026

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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 #3 – No documented evidence of progress notes from admission in February 2025 to June 2025 on file for department review.	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future, back up caregivers will be taught how to properly read and document on Progress Notes on both Progress Note Forms. Progress Note will reflect each resident. Progress notes to be filed from back-up caregivers will bi-monthly for all residents. PCG or CHO will file monthly Progress Notes reports for ARCH residents, and bi-monthly for E-ARCH residents.</p> <p>Progress notes will be reviewed 10 days after service month to ensure compliance with DOH rules and that all caregivers have sufficient time to update residents file. Full compliance checks on Progress Notes will be done every 3 months by CHO and PCG for compliance. Special review of Progress notes will be done 45 days to Annual Inspection. Such review dates will also be on ARCH calendars, both digital and hard copy so all caregivers can review Progress Notes and that they are properly completed.</p> <p>Progress Notes will be available to nurse case managers review if resident is an E-ARCH resident. Nurse case managers will be asked to mark in their monthly assessments that Progress Notes were reviewed in there monthly progress notes.</p>	<p style="text-align: center;">1/10/2026</p> <p style="text-align: right;">DVF</p>

**RECEIVED**  
JAN 16 2026

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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><b><u>FINDINGS</u></b> Resident #1, Resident #2 – No documented evidence of residents' response to medications, treatments, diets, and care plans for the past twelve (12) months on file for department review.</p>	<p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	

RECEIVED  
JAN 16 2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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><b><u>FINDINGS</u></b> Resident #1, Resident #2 – No documented evidence of residents' response to medications, treatments, diets, and care plans for the past twelve (12) months on file for department review.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future, back up caregivers will be taught how to properly read and document on Progress Notes on both Progress Note Forms. Caregivers will also be taught how to properly notate responses to medication, treatments, diets and care plans. Progress Note will reflect each resident. Progress notes to be filed from back-up caregivers will bi-monthly for all residents. PCG or CHO will file monthly Progress Notes reports for ARCH residents, and bi-monthly for E-ARCH residents. Progress notes will be reviewed 10 days after service month to ensure compliance with DOH rules and that all caregivers have sufficient time to update residents file. Full compliance checks on Progress Notes will be done every 3 months by CHO and PCG for compliance. Special review of Progress notes will be done 45 days to Annual Inspection. Such review dates will also be on ARCH calendars, both digital and hard copy so all caregivers can review Progress Notes and that they are properly completed. Progress Notes will be available to nurse case managers review if resident is an E-ARCH resident. Nurse case managers will be asked to mark in their monthly assessments that Progress Notes were reviewed in there monthly progress notes.</p>	<p>1/10/2026</p> <p style="text-align: right;">DU7</p>

**RECEIVED**  
JAN 16 2026

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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><b><u>FINDINGS</u></b> Resident #3 – No documented evidence of residents' response to medications, treatments, diets, and care plans from admission in February 2025 to June 2025 on file for department review.</p>	<p>PART 1</p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	

RECEIVED  
JAN 16 2026

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<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><b><u>FINDINGS</u></b> Resident #3 – No documented evidence of residents' response to medications, treatments, diets, and care plans from admission in February 2025 to June 2025 on file for department review.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future, back up caregivers will be taught how to properly read and document on Progress Notes on both Progress Note Forms. Caregivers will also be taught how to properly notate responses to medication, treatments, diets and care plans. Progress Note will reflect each resident. Progress notes to be filed from back-up caregivers will bi-monthly for all residents. PCG or CHO will file monthly Progress Notes reports for ARCH residents, and bi-monthly for E-ARCH residents. Progress notes will be reviewed 10 days after service month to ensure compliance with DOH rules and that all caregivers have sufficient time to update residents file. Full compliance checks on Progress Notes will be done every 3 months by CHO and PCG for compliance. Special review of Progress notes will be done 45 days to Annual Inspection.</p> <p>Such review dates will also be on ARCH calendars, both digital and hard copy so all caregivers can review Progress Notes and that they are properly completed. Progress Notes will be available to nurse case managers review if resident is an E-ARCH resident. Nurse case managers will be asked to mark in their monthly assessments that Progress Notes were reviewed in there monthly progress notes.</p>	<p style="text-align: center;">1/10/2026</p> <p style="text-align: right;">DUF</p>

RECEIVED

JAN 16 2026

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §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.  <b><u>FINDINGS</u></b> Resident #1, Resident #2, Resident #3 – No documented evidence of a current inventory of belongings on file for department review.	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>CHO, myself (Care Home Operator) and my caregivers did a manual count on all residents' belongings and compare to move in belongings when resident first entered ARCH. Residents #1 and #2 had old count from move in, Resident #3 had moved into my ARCH with only cloths on his back and slowly gained new clothes while residing in our ARCH. Currently all residents have a properly accounted and documented inventory.</p>	<p style="text-align: center;">11/30/2025</p> <p style="text-align: center;"><i>DUA</i></p>

**RECEIVED**  
JAN 16 2026

	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<input checked="" type="checkbox"/>	<p>§11-100.1-19 <u>Resident accounts.</u> (d) An accurate written accounting of resident's money and disbursements shall be kept on an ongoing basis, including receipts for expenditures, and a current inventory of resident's possessions.</p> <p><b><u>FINDINGS</u></b> Resident #1, Resident #2, Resident #3 – No documented evidence of a current inventory of belongings on file for department review.</p>	<p style="text-align: center;"><b>PART 2</b></p> <p style="text-align: center;"><b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>In the future all CG's will be asked to participate in a quarterly audit on resident binders to assure all residents have their belongings properly accounted for and tagged for disposal should belongings be inadequate for their continued use. Resident families will also be notified should their love ones need more supplies of clothing or other necessary items for their personal use and will be documented accordingly.</p>	<p>11/30/2025</p> <p style="font-size: 2em; font-family: cursive;">DVT</p>

RECEIVED

JAN 16 2026

Licensee's/Administrator's Signature: Daniel V. Felarca

Print Name: Daniel V Felarca

Date: 12/01/2025

Licensee's/Administrator's Signature: Daniel V. Felarca

Print Name: Daniel V Felarca

Date: 12/01/2025

RECEIVED  
JAN 16 2026