Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Kuuleia Hale	**CHAPTER 100.1**
Address: **984 Ala Lehua Street, Honolulu, Hawaii 96818**	**Inspection Date: September 12, 2025 Initial 6-month**

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
☒	§11-100.1-3 Licensing. (a) No person, group of persons, or entity shall operate an ARCH or expanded ARCH without a license previously obtained under and in compliance with this chapter and chapter 321, HRS. **FINDINGS** Initial facility license issued by the Office of Health care Assurance (OHCA) on May 12, 2025. Facility documented admitting Resident #1 on May 13, 2025. However, on the May 2025 medication administration record (MAR), care givers initialed MAR from May 1, 2025 to May 12, 2025, indicating administering medications to Resident #1 prior to facility receiving initial adult residential care home (ARCH) license. Primary Care Giver (PCG) and Substitute Care Giver (SCG) #4 confirmed during on-site inspection, to admitting Resident #1 into facility and providing care to Resident #1 prior to receiving the initial facility license on May 12, 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
☒	§11-100.1-3 Licensing. (a) No person, group of persons, or entity shall operate an ARCH or expanded ARCH without a license previously obtained under and in compliance with this chapter and chapter 321, HRS. **FINDINGS** Initial facility license issued by the OHCA on May 12, 2025. Facility documented admitting Resident #1 on May 13, 2025. However, on the May 2025 MAR, care givers initialed MAR from May 1, 2025 to May 12, 2025, indicating administering medications to Resident #1 prior to facility receiving initial ARCH license. PCG and SCG #4 confirmed during on-site inspection, to admitting Resident #1 into facility and providing care to Resident #1 prior to receiving the initial facility license on May 12, 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?** **Revised Corrective Action Statement** **Immediate Corrective Action Taken for the Identified Deficiency** No immediate corrective action was taken to alter or amend existing documentation. The facility acknowledges that **changing dates or entries on previously completed records is not appropriate** and understands that correcting this deficiency after-the-fact is **not practical or acceptable**. All original documentation remains unchanged and intact. **Future Corrective Action Plan** To ensure compliance moving forward, the facility will implement the following actions: 1. **Documentation Integrity** o The Administrator and RN Consultant will ensure that all documentation is completed **accurately, contemporaneously, and dated correctly at the time of entry**. o Staff will be instructed that **entries may not be altered, backdated, or modified** once completed, in accordance with ethical and regulatory standards. 2. **Staff Education**	

		○ The Administrator and RN Consultant will provide re-education to all relevant staff on proper documentation practices, including date accuracy and correction procedures (e.g., late entries with appropriate notation). 3. **Oversight and Review** ○ The Administrator will review resident documentation **weekly for four (4) weeks**, then **monthly**, to ensure ongoing compliance with documentation standards. ○ Any documentation concerns will be addressed immediately through coaching and corrective instruction. 4. **Policy Reinforcement** ○ Facility policies related to documentation standards and record integrity will be reviewed and reinforced to prevent recurrence of this deficiency.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-3 Licensing. (b)(1)(I) Application. 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: 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; **FINDINGS** Household Member (HHM) #1 – No documented evidence that HHM #1 does not have any prior felony or abuse convictions in a court of law on file.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** **Immediate Correction Completed:** 1. **Background Clearance Obtained:** o On **Oct 14, 2025**, I immediately requested and obtained the required criminal background check for Household Member #1 through the appropriate state agency (e.g., eCrim or the Hawai'i Criminal Justice Data Center). o The documentation confirming that HHM #1 has **no felony or abuse convictions** has been received and is now filed in the facility's personnel/household member compliance folder. 2. **Documentation Filed and Verified:** o The verification form and supporting documents have been placed in HHM #1's personnel/household file, clearly labeled and accessible for future inspections.	9/30/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-3 Licensing. (b)(1)(I) Application. 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: 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; **FINDINGS** Household Member (HHM) #1 – No documented evidence that HHM #1 does not have any prior felony or abuse convictions in a court of law on file.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** 1. **Creation of a Compliance Checklist:** o A **Household Member Compliance Checklist** has been created. o This checklist includes mandatory items such as: ▪ Criminal history clearance ▪ Protective services check (APS/CPS, if applicable) ▪ TB clearance ▪ ID verification o No household member will be allowed to reside or work in the home without completing *all* requirements on this checklist. 2. **Annual Monitoring & Re-verification:** o Background checks will be **reviewed annually** to ensure documentation is current and maintained in each member's file. 3. **Pre-Screening Process for New Household Members:** o Any new household member will be required to complete a criminal background clearance **before moving in or helping with resident care**.	

		○ Documentation must be provided and filed before approval is granted. 4. **Administrative Oversight:** ○ The Administrator will personally review files **monthly** to ensure all documentation is present, up-to-date, and compliant with OHCA regulations. ○ Any missing documentation will be corrected immediately. 5. **Secure and Organized Filing System:** ○ All household member compliance records will be kept in a dedicated folder, clearly organized by name, ensuring ease of access during audits or inspections. **Statement of Compliance:** I understand the importance of ensuring resident safety and maintaining regulatory compliance. The steps outlined above have been completed, and systems have been established to ensure this issue will not reoccur.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-7 General operational policies. (a)(1) General operational policies of an ARCH or expanded ARCH shall be submitted by the applicant in writing to the department prior to licensure and shall include, but shall not be limited to: Admission policies as specified in section 11-100.1-10; **FINDINGS** Resident #1 – Documentation in resident's chart reported resident needing extensive or total assistance in four (4) out of the six (6) activities of daily living (ADLs) scored. Resident does not meet the admission guidelines for the facility, per facility's general operational policy (GOP).	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** At the time of review, the level of care for **Resident #1** was determined to be **Expanded Adult Residential Care Home (E-ARCH)** due to a change in condition and increased care needs. A **family conference** was conducted with the resident's **Primary Care Provider (PCP)** and **Power of Attorney (POA)** to discuss the resident's condition and appropriate level of care. During the conference, the **POA requested additional time to identify and select an appropriate Expanded ARCH** placement for Resident #1. The facility continued to coordinate with the POA and PCP during this period while planning for a safe transition. Resident was discharged to an appropriate care home that is licensed and equipped to meet her assessed level of care needs.	9/26/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-7 General operational policies. (a)(1) General operational policies of an ARCH or expanded ARCH shall be submitted by the applicant in writing to the department prior to licensure and shall include, but shall not be limited to: Admission policies as specified in section 11-100.1-10; **FINDINGS** Resident #1 – Documentation in resident's chart reported resident needing extensive or total assistance in four (4) out of the six (6) ADLs scored. Resident does not meet the admission guidelines for the facility, per facility's GOP.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** **Future Plan to Sustain Compliance and Prevent Recurrence of Deficiency** The facility is committed to ensuring full and ongoing compliance with the Hawai'i Administrative Rules (HAR) and the facility's General Operational Policies (GOP) regarding admission and retention of residents whose care needs fall within approved ADL thresholds. To maintain long-term adherence, the following future plan will be implemented: **1. Strengthening of Admission & Retention Procedures** • A formal **Admission Eligibility Protocol** will be adopted, requiring that all prospective residents undergo a standardized ADL assessment performed by a licensed nurse prior to acceptance. • The facility will require **annual review and re-approval** of the Admission Eligibility Protocol to ensure continued alignment with updated OHCA regulations. • Residents will only be admitted or retained if their assessed ADLs remain within the scope of services	

		authorized for the facility's license level.
		
		2. Annual Staff Training and Competency Validation
		
		• All caregivers, substitute caregivers, and administrative personnel will undergo **annual training** on:
		  ○ ADL scoring accuracy
		  ○ Admission/retention criteria
		  ○ Documentation standards required under HAR
		  ○ Identifying residents who may be approaching a higher level of care
		• Training will include **competency testing**, with staff required to demonstrate accurate ADL scoring, recognition of level-of-care changes, and proper reporting of resident condition changes.
		
		3. Quarterly Multidisciplinary Review of All Residents
		
		• The facility will conduct **quarterly ADL compliance reviews** for every resident, led by the Administrator and RN Supervisor.
		• The review will evaluate:
		  ○ Current ADL levels
		  ○ Changes in resident functional status
		  ○ Whether the resident continues to meet facility retention criteria
		  ○ The need for physician updates, care plan revisions, or family conferences
		• Residents showing functional decline will be flagged for **early intervention**, preventing	

		inappropriate retention.
		
		4. Updated Documentation and Care Planning System
		
		• The facility will maintain a **centralized ADL tracking log** to identify trends and potential compliance risks.
		• Each resident's chart will include:
		  o Current ADL assessment
		  o Updated comprehensive care plan
		  o Physician orders aligned with current needs
		  o Documentation of discussions with families and providers regarding any level-of-care changes
		• The facility will transition to a **monthly documentation audit**, ensuring accuracy, consistency, and compliance with licensing expectations.
		
		5. Strengthened Collaboration With Healthcare Providers & Responsible Parties
		
		• The facility will schedule **semiannual care conferences** for all residents requiring moderate to extensive ADL support.
		• Any resident nearing ADL thresholds will trigger immediate:
		  o Physician consultation
		  o Notification to the responsible party
		  o Review of options for continued safe placement
		• The facility will develop a structured **Communication Policy**, ensuring all parties receive timely updates related to condition	

		changes and regulatory requirements.
		
		6. Ongoing Quality Assurance and Performance Improvement (QAPI) Measures
		
		• A QAPI committee will review ADL compliance, admission procedures, and retention cases **quarterly**, documenting all findings and corrective actions.
		• Any identified variance or borderline case will result in:
		  o Immediate root-cause analysis
		  o Policy adjustments
		  o Staff retraining as needed
		• QAPI data will be used annually to revise policies and update staff training content.
		
		7. Annual Policy Review and Regulatory Alignment
		
		• The facility will conduct an **annual review of all GOP policies** related to admission, retention, and ADL thresholds to ensure consistency with HAR and updated OHCA guidelines.
		• Changes in regulations, staffing patterns, or resident needs will prompt policy updating and dissemination to all staff.
		
		Completion and Ongoing Maintenance
		
		• The above future plan will be reviewed every **12 months**, with updates documented and submitted to licensing authorities upon request.
		• The Administrator will ensure consistent enforcement of all policies and report significant	

		compliance issues to OHCA if required.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. **FINDINGS** PCG, SCG #1, SCG #2, SCG, #3, SCG #4, SCG #5, HHM #1, HHM #2 – No documented evidence of a current physical examination clearance by a physician or advanced practice registered nurse (APRN) on file.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** **Plan of Correction (Immediate Actions Completed)** 1. **Obtain Current Physical Clearances** • The Administrator immediately contacted each affected staff member to obtain current physical examination documentation from their physician or APRN. • All physical examination clearances were received and filed in personnel records by //2025. 2. **Staff Records Audit** • A full audit of all staff personnel files was conducted to ensure that **current physical examination clearance** is on file for every employee. • Any missing or expired documentation was immediately corrected. 3. **Staff Re-Education Completed** • All staff were re-educated regarding the requirement	9/30/2025

		for **current physical examination clearance** as a condition of employment, in compliance with OHCA regulations. • Staff were instructed to provide updated clearances before expiration of current documentation. • Signed acknowledgment forms have been filed in personnel records.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-9 Personnel, staffing and family requirements.
	(a)
	All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.
	
	FINDINGS
	PCG, SCG #1, SCG #2, SCG, #3, SCG #4, SCG #5, HHM #1, HHM #2 – No documented evidence of a current physical examination clearance by a physician or APRN on file.
		PART 2
		
		FUTURE PLAN
		
		USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?
		
		Future Plan to Prevent Reoccurrence
		
		1. **Annual Physical Clearance Policy Implementation**
		
		• The facility's policy now requires that all staff provide **current physical examination clearance annually** prior to expiration.
		• Documentation must be received and filed in personnel records **before the expiration date** of the prior physical.
		
		2. **Personnel File Checklist Updated**
		
		• A **Personnel File Compliance Checklist** has been updated to include:
		  o Verification of current physical clearance
		  o Expiration date noted in the file
		• This checklist will be completed and reviewed by the Administrator for all staff upon hire and annually.
		
		3. **Administrator Monthly Audit**	

		• The Administrator will conduct a **monthly review of all staff files** to verify:
		  ○ Physical clearance is current and documented
		  ○ Any expiring physicals are flagged **at least 30 days in advance** for follow-up
		• Findings and corrective actions will be documented in the QA log.
		
		4. **Staff Training & Reminders**
		
		• Staff will be reminded quarterly of the requirement for current physical examination clearance.
		• Written reminders will be sent **30 days prior to expiration** of current clearance to allow staff time to schedule an updated physical.
		
		5. **Integration Into QAPI Program**
		
		• Compliance with annual physical clearances will be included as a **QAPI performance indicator**.
		• Monthly trends, missing documentation, or late submissions will trigger corrective actions and retraining.
		
		6. **Administrator Oversight & Accountability**
		
		• The Administrator is responsible for ensuring **100% compliance** with physical clearance documentation for all staff.
		• Any staff member without a current clearance will be	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** PCG, SCG #1, SCG #2, HHM #1, HHM #2 – No documented evidence of a current tuberculosis clearance by a physician or APRN on file.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** **Plan of Correction (Immediate Actions Completed)** 1. **Obtain Current TB Clearance** • The Administrator immediately contacted each affected staff member to obtain current TB clearance documentation from their physician or APRN. • All current TB clearances have been received and filed in the personnel records by //2025. 2. **Personnel File Audit** • A full audit of all staff personnel files was conducted to ensure that **current TB clearance** is on file for every employee. • Any missing or expired documentation was immediately corrected. 3. **Staff Re-Education Completed** • All staff were re-educated on the requirement to maintain **current TB clearance** in compliance with OHCA regulations. • Staff were informed that TB clearance must be provided **prior to hire** and renewed as required by	10/1/2025

		policy. • Staff signed acknowledgment forms confirming understanding, which have been filed in personnel records.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** PCG. SCG #1, SCG #2, HHM #1, HHM #2 – No documented evidence of a current tuberculosis clearance by a physician or APRN on file.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** **Future Plan to Prevent Reoccurrence** 1. **TB Clearance Policy Implementation** • Facility policy now requires all staff to submit a **current TB clearance** prior to employment and **annually thereafter**. • TB clearance documentation must be received and filed in the personnel record **before the expiration of the previous clearance**. 2. **Personnel File Checklist Updated** • A **Personnel File Compliance Checklist** now includes verification of TB clearance with expiration dates clearly noted. • The Administrator will review the checklist for all staff upon hire and annually to ensure compliance. 3. **Monthly Administrator Audit** • The Administrator will conduct a **monthly audit of all staff files** to verify: o TB clearance is current and documented	

		○ Any expiring clearances are flagged **30 days in advance** for follow-up • Audit findings will be recorded in the QA log. 4. **Quarterly Staff Training & Reminders** • Staff will receive **quarterly reminders** of TB clearance requirements and expiration dates. • Written reminders will be sent to staff **30 days prior to expiration** of their TB clearance to allow sufficient time for renewal. 5. **Integration into QAPI Program** • TB clearance compliance will be included as a **QAPI performance indicator**. • Any gaps or non-compliance will trigger immediate corrective action and retraining. 6. **Administrator Oversight & Accountability** • The Administrator is responsible for ensuring **100% compliance** with TB clearance requirements for all staff. • Any staff member without current TB clearance will be **prohibited from providing care** until documentation is submitted and verified.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-10 Admission policies. (d) The Type I ARCH shall only admit residents at appropriate levels of care. The capacity of the Type I ARCH shall also be limited by this chapter, chapter 321, HRS, and as determined by the department. **FINDINGS** Resident #1 – Most recent level of care evaluation done on 3/4/2025, prior to the admission date of the resident into the facility, 5/13/2025. As noted on progress notes, resident needs maximum assistance in ADLs. Resident exceeds the appropriate level of care as determined by issued license.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** At the time of review, the level of care for **Resident #1** was determined to be **Expanded Adult Residential Care Home (E-ARCH)** due to a change in condition and increased care needs. A **family conference** was conducted with the resident's **Primary Care Provider (PCP)** and **Power of Attorney (POA)** to discuss the resident's condition and appropriate level of care. During the conference, the **POA requested additional time to identify and select an appropriate Expanded ARCH** placement for Resident #1. The facility continued to coordinate with the POA and PCP during this period while planning for a safe transition. Resident was discharged to an appropriate care home that is licensed and equipped to meet her assessed level of care needs.	10/1/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-10 Admission policies. (d) The Type I ARCH shall only admit residents at appropriate levels of care. The capacity of the Type I ARCH shall also be limited by this chapter, chapter 321, HRS, and as determined by the department. **FINDINGS** Resident #1 – Most recent level of care evaluation done on 3/4/2025, prior to the admission date of the resident into the facility, 5/13/2025. As noted on progress notes, resident needs maximum assistance in ADLs. Resident exceeds the appropriate level of care as determined by issued license.	**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 ongoing compliance with Hawai'i Administrative Rules (HAR) and the facility's General Operational Policy (GOP) regarding resident admission, retention, and level-of-care requirements, preventing future occurrences of admitting or retaining residents whose care needs exceed licensed capacity. **1. Strengthened Admission & Retention Protocols** • All prospective residents will undergo a **comprehensive Level of Care (LOC) assessment** conducted by a licensed RN within **30 days prior to admission**. • The **Administrator or RN Supervisor** must review and approve all admissions based on assessment outcomes and licensed scope of services. • **Documentation** verifying eligibility and compliance with ADL thresholds will be maintained in each resident's chart.	

		2. Staff Training & Competency Assurance
		
		• All caregivers, substitute caregivers, and administrative staff will receive **annual training** on:
		  ○ ADL scoring and documentation
		  ○ Level-of-care assessment and retention criteria
		  ○ Admission eligibility procedures and regulatory compliance
		• Competency will be validated via testing or simulation exercises, and records will be maintained in personnel files.
		
		3. Ongoing Monitoring & Auditing
		
		• The RN Supervisor will perform **monthly audits** of all residents' ADL assessments and LOC evaluations.
		• Residents approaching or exceeding licensed ADL thresholds will be flagged for:
		  ○ Immediate care plan review
		  ○ Physician consultation
		  ○ Notification to responsible party
		• Audit results will be reviewed **quarterly by the QAPI committee** to evaluate compliance trends and implement corrective measures if needed.
		
		4. Care Conference & Family Communication
		
		• Residents with high-level care needs will have **semiannual care conferences** with the responsible party, RN, and Administrator.
		• The facility will provide **clear documentation and**	

		communication regarding scope of care limitations and potential need for transfer if level-of-care needs exceed licensed capacity. **5. Policy Review & Continuous Improvement** • The facility will **annually review its General Operational Policy (GOP)** and admission criteria to ensure alignment with OHCA regulations. • Any updates in licensing rules, resident acuity trends, or operational practices will trigger **policy revision and staff retraining**. **6. Accountability & Responsible Party** • **Administrator** is responsible for ensuring: o Implementation of the future plan o Monitoring of compliance o Documentation of corrective measures and ongoing audits **7. Implementation Timeline** • Immediate corrective measures: **Completed** • Systemic and preventive measures: **Fully implemented within 30 days of POC submission** • Ongoing monitoring: **Continuous, reviewed quarterly.** This future plan demonstrates **long-term commitment to resident safety, regulatory compliance, and proactive prevention**.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-10 Admission policies. (g)
	An inventory of all personal items brought into the Type I ARCH by the resident shall be maintained.
	
	FINDINGS
	Resident #4 – Resident admitted on 5/13/2025. No documented evidence of an inventory of belongings done on admission or since then.
		PART 1
		
		DID YOU CORRECT THE DEFICIENCY?
		
		USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY
		
		1. Immediate Correction for Resident #4
		
		• On **Sept 13, 2025**, a complete **Inventory of Personal Belongings** was completed for Resident #4 by the Administrator and caregiver team.
		• The inventory was reviewed and signed by:
		  o Resident or responsible party (POA)
		  o Administrator
		  o On-duty caregiver
		• A copy was placed in Resident #4's chart, and another copy was provided to the responsible party.
		• All staff were reminded of the requirement to complete a belongings inventory **on the day of admission**.
		
		2. Systemic Corrective Measures to Prevent Recurrence
		
		• The **Admission Checklist** has been updated to include a mandatory line item stating: **"Inventory of resident belongings completed and signed before room assignment."**
		• No resident will be fully admitted or assigned to a room unless belongings are documented, reviewed, and signed.
		• All caregivers and substitute caregivers received
			9/26/2025

		retraining on: o Proper inventory documentation o Storage, safeguarding, and logging of resident property o Facility policy on personal belongings and liability documentation • A standardized **Resident Belongings Inventory Form** was implemented facility-wide for all future admissions. **3. Ongoing Monitoring & Quality Assurance** • The Administrator or RN Supervisor will perform **monthly audits** of all resident charts to ensure: o A completed belongings inventory is present o Updates are made if new items are brought in or removed • Any missing or incomplete inventories will result in: o Immediate completion o Staff retraining and documentation • Monitoring results will be reviewed during **quarterly QAPI meetings** to evaluate compliance trends and identify needed improvements. Responsible for ensuring completion of corrective actions, monitoring chart audits, and maintaining admission compliance. **5. Date of Completion**	

		• Immediate correction for Resident #4 completed on: **Sept 13, 2025.** • Systemic corrective actions fully implemented by: **Sept 13, 2025.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-10 Admission policies. (g)
	An inventory of all personal items brought into the Type I ARCH by the resident shall be maintained.
	
	FINDINGS
	Resident #4 – Resident admitted on 5/13/2025. No documented evidence of an inventory of belongings done on admission or since then.
		PART 2
		
		FUTURE PLAN
		
		USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?
		
		Sustaining Compliance with Personal Belongings Documentation
		
		1. Strengthened Admission Procedures
		
		• All new admissions will require a **completed, signed belongings inventory** before the admission packet can be marked "complete."
		• The belongings form will be electronically cross-checked with the new **Admission Compliance Checklist** during orientation.
		
		2. Staff Education & Annual Competency
		
		• Annual training will cover:
		  ○ Required admission documents
		  ○ Proper completion of belongings inventory
		  ○ Chain-of-custody principles for valuables
		• Competency verification will be documented in each staff member's personnel file.
		
		3. Continuous Monitoring & Documentation Updates
		
		• The facility will maintain a **Belongings Update**	

		Log, requiring staff to document new items or removed items during: ○ Quarterly care conferences ○ Family visits ○ Notable room changes • The RN Supervisor will perform **quarterly checks** to ensure inventories remain accurate and updated. **4. Policy Review & Continuous Improvement** • The facility's General Operational Policies (GOP) regarding belongings and property management will undergo **annual review**. • Any changes in HAR or OHCA guidance will trigger immediate policy revision and staff retraining. **5. Accountability & Implementation** • The Administrator will maintain final oversight, ensuring: ○ Admission packets are thoroughly reviewed ○ Inventory forms are properly completed ○ Monitoring systems are consistently followed ○ QAPI findings lead to improvements and policy adjustments. **6. Implementation Timeline** • Future plan takes effect immediately upon acceptance of this Plan of Correction. • Ongoing monitoring and annual reviews will	

		continue indefinitely.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-13 Nutrition. (b)
	Menus shall be written at least one week in advance, revised periodically, dated, and followed. If cycle menus are used, there shall be a minimum of four weekly menus.
	
	FINDINGS
	Facility using cycle menu #2 during inspection. Food offered to residents does not follow posted menu. No substitution menu available in facility.
		PART 1
		
		DID YOU CORRECT THE DEFICIENCY?
		
		USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY
		
		1. Immediate Correction
		
		• On **Sept. 13, 2025**, the Administrator reviewed all meals being served and immediately aligned food preparation with the posted **Cycle Menu #2**.
		• A **Substitution Menu Log** was created and placed in the kitchen for staff to record any menu substitutions, including the date, reason for substitution, and nutritional equivalence.
		• All caregivers responsible for meal service were reeducated on:
		  ○ Following the posted cycle menu
		  ○ Documenting any substitutions
		  ○ Ensuring meals meet nutritional requirements
		• The posted menu was reviewed and confirmed to be compliant with minimum dietary standards.
		
		2. Systemic Corrective Measures
		
		• The facility implemented a **Mandatory Meal Preparation Procedure**, requiring staff to check:
		  1. The posted menu each morning
		  2. The ingredients required
		  3. Approved substitutions (if necessary)
			10/1/2025

		• A **Weekly Menu Verification Checklist** was created to ensure:
		  o Menu is posted in an accessible location
		  o Ingredients match the planned meals
		  o Substitution forms are completed when applicable
		• The Administrator or RN Supervisor will now initial the menu weekly to confirm its accuracy and readiness.
		
		3. Ongoing Monitoring & Quality Assurance
		
		• The Administrator or a designated staff member will conduct **weekly audits** of:
		  o Meals served versus the posted menu
		  o Completeness of substitution logs
		  o Availability of required food items
		• Findings will be reviewed during **monthly staff meetings** and **quarterly QAPI meetings**.
		• Noncompliance will result in immediate retraining and documentation.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-13 Nutrition. (b)
	Menus shall be written at least one week in advance, revised periodically, dated, and followed. If cycle menus are used, there shall be a minimum of four weekly menus.
	
	FINDINGS
	Facility using cycle menu #2 during inspection. Food offered to residents does not follow posted menu. No substitution menu available in facility.
		PART 2
		
		FUTURE PLAN
		
		USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?
		
		Sustaining Menu & Food Service Compliance
		
		1. Meal Service Compliance Reinforcement
		
		• The posted cycle menu will be reviewed and updated **every 4 weeks** to ensure ongoing compliance with resident preferences, dietary restrictions, and nutritional standards.
		• Substitution menus will always be available and kept posted alongside the main menu.
		
		2. Staff Training & Annual Competency
		
		• All caregivers involved in food preparation will complete **annual training** covering:
		  ○ Menu compliance
		  ○ Substitution documentation
		  ○ Maintaining dietary equivalence
		  ○ All food safety requirements (HAR §17-895 standards)
		• Training will include **practical demonstrations** to ensure competence.	

		3. Dietary Documentation System
		
		• A **Substitution Menu Binder** will be maintained in the kitchen, including:
		  o Daily substitution logs
		  o Approved nutritionally equivalent alternatives
		  o Notes for special diets (soft, mechanical soft, diabetic, low sodium)
		• All logs will be stored for **minimum 1 year** for licensing review.
		
		4. Ongoing Monitoring & Audits
		
		• A **Monthly Food Service Audit Form** will be used to monitor:
		  o Menu accuracy
		  o Substitution compliance
		  o Food inventory
		  o Resident satisfaction
		• The Administrator will review audit findings and ensure trends are addressed promptly.
		
		5. Policy Review & Continuous Improvement
		
		• The facility's Food Service Policy will be reviewed **annually or upon regulatory updates**.
		• QAPI will evaluate menu compliance quarterly and adjust processes as needed.
		
		6. Accountability
		
		• The Administrator maintains full responsibility for:	

		○ Compliance ○ Monitoring ○ Staff competency ○ Documentation • Deviations will trigger corrective action and re-training.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-13 Nutrition. (i)
	Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit.
	
	FINDINGS
	Resident #5 – Physician ordered "regular texture, thin liquids" as a diet order on 7/17/2025. Diet order incomplete.
		PART 1
		
		DID YOU CORRECT THE DEFICIENCY?
		
		USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY
		
		1. CORRECTION PLAN (Immediate Correction)
		
		a. Immediate Action Taken:
		
		• On **Oct 1, 2025**, the facility contacted Resident #5's Primary Care Provider (PCP) and obtained a **complete and comprehensive diet order**, including:
		  ○ Diet texture
		  ○ Liquid consistency
		  ○ Caloric considerations (if applicable)
		  ○ Allergies
		  ○ Any restrictions or physician-specific instructions
		• The updated diet order has been added to Resident #5's chart and MAR.
		• The completed dietary order has been communicated to all caregiving and kitchen staff.
		
		b. Staff Re-Education:
		
		• All caregivers and meal preparation staff have been re-educated on:
		  ○ The requirement that diet orders must be complete and signed before being
			10/1/2025

		implemented. ○ The process for clarifying incomplete or unclear diet orders with the PCP. • Staff training completed on **[insert date]** and placed in the training binder. **c. Verification:** • The Licensee reviewed all current residents' charts to ensure **all diet orders are complete and updated**. • Any missing or unclear diet orders were corrected immediately. **d. Responsible Person:** • **Licensee / Administrator** • **Dietary Supervisor (if applicable)** • **Primary Caregivers**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (i) Each resident shall have a documented diet order on admission and readmission to the Type I ARCH and shall have the documented diet annually signed by the resident's physician or APRN. Verbal orders for diets shall be recorded on the physician order sheet and written confirmation by the attending physician or APRN shall be obtained during the next office visit. **FINDINGS** Resident #5 – Physician ordered "regular texture, thin liquids" as a diet order on 7/17/2025. Diet order incomplete.	**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. Diet Order Verification Protocol:** Effective immediately, the facility will implement a **Diet Order Verification Checklist** requiring that every diet order include: • Diet texture level • Liquid consistency • Allergies • Restrictions (sodium, sugar, fluid restriction, etc.) • Physician signature • Date of order A caregiver cannot place a new diet order into effect until the checklist is complete. **b. Admission & Change-of-Condition Diet Procedure:** • Upon **admission**, any unclear diet order will immediately be clarified with the resident's doctor before implementation. • Upon **change of condition**, the PCP will be contacted to verify and update dietary orders in writing.	

		c. Substitutions & Modifications:
		
		• Any diet modification or adjustment must be supported by a doctor's written order before being implemented.
		
		d. Staff Training Plan:
		
		• All staff involved in food service or caregiving will receive **quarterly training** on:
		  ○ Reading diet orders
		  ○ Identifying missing components
		  ○ When and how to request clarification from PCP
		  ○ Documentation and MAR accuracy
		• Training will be logged and filed for OHCA review.
		
		e. MAR & Kitchen Binder Alignment:
		
		• The Licensee will ensure diet orders in the resident chart **match the MAR and the kitchen binder**.
		• Weekly comparison audits will be done every **Monday morning** by the Licensee or designated supervisor.
		
		f. Monthly Diet Order Audit:
		
		• A **monthly audit** of all residents' diet orders will be conducted to ensure completeness, accuracy, and currency.
		• Any discrepancy will be corrected immediately.
		
		g. QAPI Inclusion:	

		• Diet-order accuracy will be added to the facility's **QAPI program** as a monitored item. • Trends, staff errors, or repeated deficiencies will trigger corrective staff training. **3. Statement of Ongoing Compliance** The facility is committed to ensuring all dietary orders are complete, accurate, and updated at all times. Policies and verification processes are now in place to prevent recurrence and ensure compliance with OHCA dietary care standards.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. **FINDINGS** Resident #2 - Observed "Refresh Tears" eye drops unsecured & unlabeled on bedside table.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** **IMMEDIATE CORRECTION (Corrective Action Taken)** **a. Immediate Removal & Securing of Medication** • Upon discovery on **Septn12 2025**, the eye drops were immediately removed from the bedside table. • Medication was secured in the **locked medication storage area** per facility policy. **b. Verification & Labeling** • Medication was checked against the resident's MAR for accuracy. • A **proper pharmacy label** was obtained before returning the medication to the secure storage. **c. Resident & Staff Safety Actions** • Caregivers were reminded that **no medication—prescribed or OTC—may be left unattended in resident rooms**, regardless of resident's functional level. • Resident education provided regarding safe handling	9/12/2025

		of medications. **d. Documentation Completed** • An incident notation was added to Resident #2's chart. • Corrective action logged in the medication management file. **e. Responsible Person** • **Licensee / Medication Supervisor** **2. SYSTEMIC CORRECTIVE ACTIONS** (Ensures the problem is corrected facility-wide) **a. Full Medication Storage Audit** • All resident rooms, common areas, and bathrooms were inspected for unsecured medications. • Any discovered items were secured immediately. • Audit completed on **[insert date]**. **b. Staff Re-Education** All caregivers were re-trained on: • Medication storage requirements • Labeling requirements • Prohibited bedside storage of medications • Procedures for OTC/non-prescription items • Immediate reporting of policy violations	

		Training completed on **[insert date]** and filed in staff training binder. **c. Medication Policy Review** • Medication storage section of the facility's **General Operational Policy (GOP)** was reviewed and updated for clarity. • Staff signed acknowledgement of updated policy.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-15 Medications. (a)
	All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms.
	
	FINDINGS
	Resident #2 - Observed "Refresh Tears" eye drops unsecured & unlabeled on bedside table.
		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. Weekly Room Medication Checks
		
		• A **daily audit** of all resident rooms will be conducted to ensure no unsecured medications or supplements are left at bedside.
		• Audit results logged and reviewed monthly by the Licensee.
		
		b. MAR, Storage & Label Alignment
		
		• All medications must match:
		  ○ MAR
		  ○ Pharmacy label
		  ○ Storage log
		• Unlabeled or mismatched items must be reported and corrected within 24 hours.
		
		c. Medication Label Verification Procedure
		
		• No medication will be added to a resident's regimen or stored in the facility unless:
		  ○ It has a **proper pharmacy label**, and
		  ○ The PCP order is received and filed.	

		• OTC medications must also be labeled and documented.
		
		d. Quarterly Staff Training
		
		• Medication management training incorporated into quarterly in-service schedule, including:
		  ○ Labeling requirements
		  ○ Storage compliance
		  ○ Handling resident self-use items
		  ○ Preventing medication diversion, contamination, or misuse
		
		e. QAPI Integration
		
		This deficiency is added to the QAPI tracking list:
		
		• Track incidents of unsecured or unlabeled medications
		• Identify patterns or staff needing additional training
		• Monthly review during QAPI meeting
		
		f. Admission Procedure Reinforcement
		
		• At admission, all personal belongings (including OTC items) will be inventoried.
		• Any medication found must be removed, labeled, documented, and secured.
		
		4. STATEMENT OF SUSTAINED COMPLIANCE
		
		The facility is committed to ensuring all medications are	

		properly labeled, secured, and managed in accordance with OHCA regulatory standards. Policies, staff training, and auditing procedures have been strengthened to prevent recurrence.	

	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 admitted 5/13/2025. No current medications orders by a physician or APRN for the following medications: "Quetiapine fumarate 25mg tab, take ½ tablet by mouth every other day, (last medication order dated 9/21/2024)" "Senna 8.6mg tab, 1 tab PO daily, (last medication order dated 4/19/2024)" and "Fexofenadine 60mg tab, 1 tab PO BID (last medication order dated 4/19/2024)" on admission or thereafter.	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
☒	§11-100.1-15 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 admitted 5/13/2025. No current medications orders by a physician or APRN for the following medications: "Quetiapine fumarate 25mg tab, take ½ tablet by mouth every other day, (last medication order dated 9/21/2024)" "Senna 8.6mg tab, 1 tab PO daily, (last medication order dated 4/19/2024)" and "Fexofenadine 60mg tab, 1 tab PO BID (last medication order dated 4/19/2024)" on admission or thereafter.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** **Future Plan to Prevent Reoccurrence:** 1. **Verification of Active Medication Orders Prior to Admission:** o A new **Admission Medication Verification Protocol** will be implemented. o Before a resident is accepted into the home, all medications listed in the transfer packet or provided by family must be confirmed with the resident's PCP, APRN, or discharging provider. o The resident will *not* be admitted until active, current orders are obtained. 2. **Mandatory Provider Reconciliation at Admission:** o On the day of admission, the Administrator or Medication Manager will conduct a **medication reconciliation**and immediately contact the resident's healthcare provider to obtain updated orders for all medications. o Documentation of the call, fax request, or portal message will be placed in the resident's chart. 3. **No Administration Without Active Orders:**	

		○ Staff will be retrained to ensure **no medication is administered** unless an active, current physician/APRN order is on file. ○ Any medication found without a valid order will be removed from active administration and placed in the **"Do Not Use"** section until a new provider order is obtained. 4. **Admission Checklist Enhancement:** ○ The Admission Checklist has been updated to include: ▪ Verification of each medication name, dose, frequency, and provider order date ▪ Confirmation that all orders are active (within the provider-acceptable timeframe) ▪ Documentation that updated orders were received and filed ○ Admission is considered incomplete until this section is fully verified. 5. **72-Hour Follow-Up System:** ○ If a provider is unavailable on the day of admission, a **mandatory 72-hour follow-up** will be completed to ensure all medication orders are received. ○ The follow-up attempt will be documented with date, time, method of contact, and provider response. 6. **Ongoing Monthly File Audits:** ○ The Administrator will perform **monthly audits** of resident medication records to ensure orders remain active, current, and consistent with what is being administered.	

		○ Any discrepancies will be corrected immediately with provider clarification. 7. **Staff Education:** ○ All staff involved in medication administration will receive refresher training on: ▪ The requirement for current provider orders ▪ Proper documentation ▪ Admission medication reconciliation ▪ Reporting medications without orders ○ Training will be documented and placed in employee files. **Statement of Assurance:** These corrective actions will ensure that all residents admitted to the care home have accurate, current, and physician/APRN-authorized medication orders. The new systems and auditing procedures will prevent this issue from reoccurring in the future.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-15 Medications. (c)
	All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.
	
	FINDINGS
	Resident #1 – Observed the following medications in residents' medication bin without a documented physician or APRN order: "Prochlorperazine 10mg tab," "Acetaminophen 650mg supp," "Lorazepam 0.5mg tab," "Onelax 10mg supp," "Hyoscyamine 0.125mg SL tab," and "Haloperidol 2ml/mg concentrate."
		PART 1
		
		DID YOU CORRECT THE DEFICIENCY?
		
		USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY
		
		1. Immediate Correction Completed
		
		• The Administrator immediately contacted the hospice agency to request **signed and current medication orders** for all medications found in the resident's bin.
		• Hospice agency provided written, signed physician/APRN orders for each medication listed above.
		• All orders have been reviewed, printed, and placed in Resident #1's medical chart.
		• Medications have now been reconciled with the updated orders to ensure accuracy and compliance.
		
		2. Medication Audit Completed
		
		• A complete review of Resident #1's medication profile was conducted.
		• All medications currently stored in the facility were verified for:
		  ○ Correct labeling
		  ○ Current physician/APRN orders
		  ○ Appropriate hospice authorization
		• Any expired, discontinued, or duplicate medications were removed from active use and disposed of
			10/2/2025

		according to policy.
		
		3. Staff Notification and Education
		
		• All caregiving and medication staff were informed of the deficiency.
		• Staff were re-educated on:
		  o The requirement that **every medication in a resident's bin must have a current provider order**
		  o Procedures for verifying hospice medication orders
		  o What to do if an order is missing or unclear
		• Staff signed training acknowledgment forms that were placed in personnel files.	

	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 – Observed the following medications in residents' medication bin without a documented physician or APRN order: "Prochlorperazine 10mg tab," "Acetaminophen 650mg supp," "Lorazepam 0.5mg tab," "Onelax 10mg supp," "Hyoscyamine 0.125mg SL tab," and "Haloperidol 2ml/mg concentrate."	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** **Future Plan to Prevent Reoccurrence** **1. Mandatory Verification of Hospice Medication Orders** • All hospice medications delivered to the home must be accompanied by a **signed, current physician/APRN order** before being placed in the resident's medication bin. • No medication will be accepted, stored, or administered without a matching written order. • If the hospice nurse drops off medications without orders, staff are required to **hold medications in a "pending verification" bin** until orders are received. **2. Hospice Admission Medication Reconciliation** • Upon hospice admission or change in level of care, the Administrator or Medication Manager will perform a **full reconciliation** with the hospice RN. • Medication list must be verified against signed orders before medications are stocked or administered.	

		• Any discrepancies will be resolved immediately with hospice. **3. Weekly Medication–Order Matching** • A **weekly audit** will be performed to confirm that each medication in the resident's bin has a corresponding active order. • The audit will be documented and maintained in the medication administration record (MAR) binder. **4. Updated Facility Policy for Hospice Medications** A revised written policy will now require: • Hospice nurses to leave **physician/APRN signed orders** for any new or changed medications. • Staff to notify the Administrator immediately if orders are missing, incomplete, or unclear. • Medications to be quarantined until proper documentation is received. **5. Staff Training and Annual Competency Review** • All staff will receive training on the new hospice medication procedure, including recognizing when orders are missing and how to document communication with hospice. • Annual competency checks will include: o Medication-order verification o Hospice collaboration o Documentation standards	

		6. Communication Protocol with Hospice
		
		• A standardized communication form will be used for:
		  ○ Requesting missing orders
		  ○ Clarifying medication changes
		  ○ Confirming verbal orders
		• All communication will be documented with date, time, provider/hospice contact, and response.
		
		Assurance of Compliance
		
		These corrective actions and preventive measures will ensure that all medications stored and administered at the facility have valid, current physician or APRN orders. The new protocols and auditing systems will prevent this deficiency from reoccurring.	

	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 – Observed "Quetiapine fumurate 25mg tab, take 1 tablet by mouth every day as needed for restlessness" in resident's medication bin. Original date filled was 6/03/2025. No physician or APRN order on file.
		PART 1
		
		DID YOU CORRECT THE DEFICIENCY?
		
		USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY
		
		Plan of Correction (Immediate Actions Completed)
		
		1. **Medication Order Verification and Correction**
		
		• The Administrator immediately contacted Resident #1's physician/APRN regarding the unapproved Quetiapine order.
		• A **written physician/APRN order** was obtained specifying:
		  ○ Medication name
		  ○ Dose
		  ○ Route
		  ○ Frequency
		  ○ Indication
		• The resident's MAR was updated to reflect the authorized order.
		• Any medication in the bin not supported by a current order was removed and returned to the pharmacy or properly disposed of according to facility policy.
		
		2. **Medication Reconciliation Completed**
		
		• All of Resident #1's medications were reviewed to ensure each medication on the MAR has a corresponding physician/APRN order.
			10/1/2025

		• Discrepancies were corrected immediately, and documentation filed in the resident's chart.
		
		3. **Staff Re-Education Completed**
		
		• All PCGs and SCGs were re-educated regarding:
		  o Never administering or stocking medications without a **current, written provider order**
		  o Proper MAR documentation and verification
		  o Immediate reporting of any discrepancies to the Administrator
		• Staff signed acknowledgment forms, now filed in personnel records.	

	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 – Observed "Quetiapine fumurate 25mg tab, take 1 tablet by mouth every day as needed for restlessness" in resident's medication bin. Original date filled was 6/03/2025. No physician or APRN order on file.
		PART 2
		
		FUTURE PLAN
		
		USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?
		
		Future Plan to Prevent Reoccurrence
		
		1. **Medication Admission & Verification Protocol**
		
		• For all new or refilled medications, the Administrator or RN will verify each medication against a written physician/APRN order **before administration or placement in the resident's bin**.
		• No medication will be administered without a valid order.
		
		2. **Monthly MAR Audit**
		
		• The Administrator will conduct **monthly MAR audits** for all residents to ensure:
		  ○ Each medication has a valid written order
		  ○ Dose, route, and frequency match the order
		  ○ No unapproved medications are present in resident bins
		• Audit findings will be documented in a **Medication QA Log**.
		
		3. **Staff Training & Competency**
			10/1/2025

		• All caregivers involved in medication administration will receive **quarterly refresher training** on:
		  ○ Medication order requirements
		  ○ MAR documentation standards
		  ○ Facility policy regarding unapproved medications
		• Training acknowledgment forms will be maintained in personnel files.
		
		4. **Administrator Oversight and Sign-Off**
		
		• The Administrator will review and sign off on all new or changed orders **within 24 hours** of receipt.
		• This ensures all new medications are authorized before administration.
		
		5. **Weekly Medication Bin Checks**
		
		• Resident medication bins will be checked **weekly** to ensure all medications match written orders.
		• Unauthorized medications will be removed immediately and documented.
		
		6. **Integration Into QAPI Program**
		
		• Medication order compliance will be monitored monthly as a **QAPI performance indicator**.
		• Any discrepancies will trigger immediate corrective action and staff retraining.	

	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 – Observed "Quetiapine fumurate 25mg tab, take 2 tablets by mouth for restlessness" in resident's medication bin. Original date filled was 8/21/2025. No physician or APRN order on file.
		PART 1
		
		DID YOU CORRECT THE DEFICIENCY?
		
		USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY
		
		I. Plan of Correction (Immediate Actions Completed)
		
		1. **Medication Order Verification and Correction**
		
		• The Administrator contacted Resident #1's physician/APRN immediately.
		• Written orders for Quetiapine fumarate were obtained, specifying:
		  ○ Dose
		  ○ Route
		  ○ Frequency
		  ○ Indication
		• The resident's MAR was updated to reflect the correct, authorized orders.
		• Any medication in the bin not matching the authorized order was removed and returned to the pharmacy or properly disposed of according to facility policy.
		
		2. **Medication Reconciliation Completed**
		
		• All of Resident #1's medications were reviewed to ensure every medication on the MAR has a **corresponding physician/APRN order**.
		• Discrepancies were corrected immediately, and
			10/1/2025

		documentation filed in the resident's chart.
		
		3. **Staff Re-Education**
		
		• All PCGs and SCGs were re-educated regarding:
		  o Never administering or stocking medication without a **current, written provider order**
		  o Proper MAR documentation and verification
		  o Reporting any discrepancies to the Administrator immediately
		• Staff signed acknowledgment forms, now placed in personnel files.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

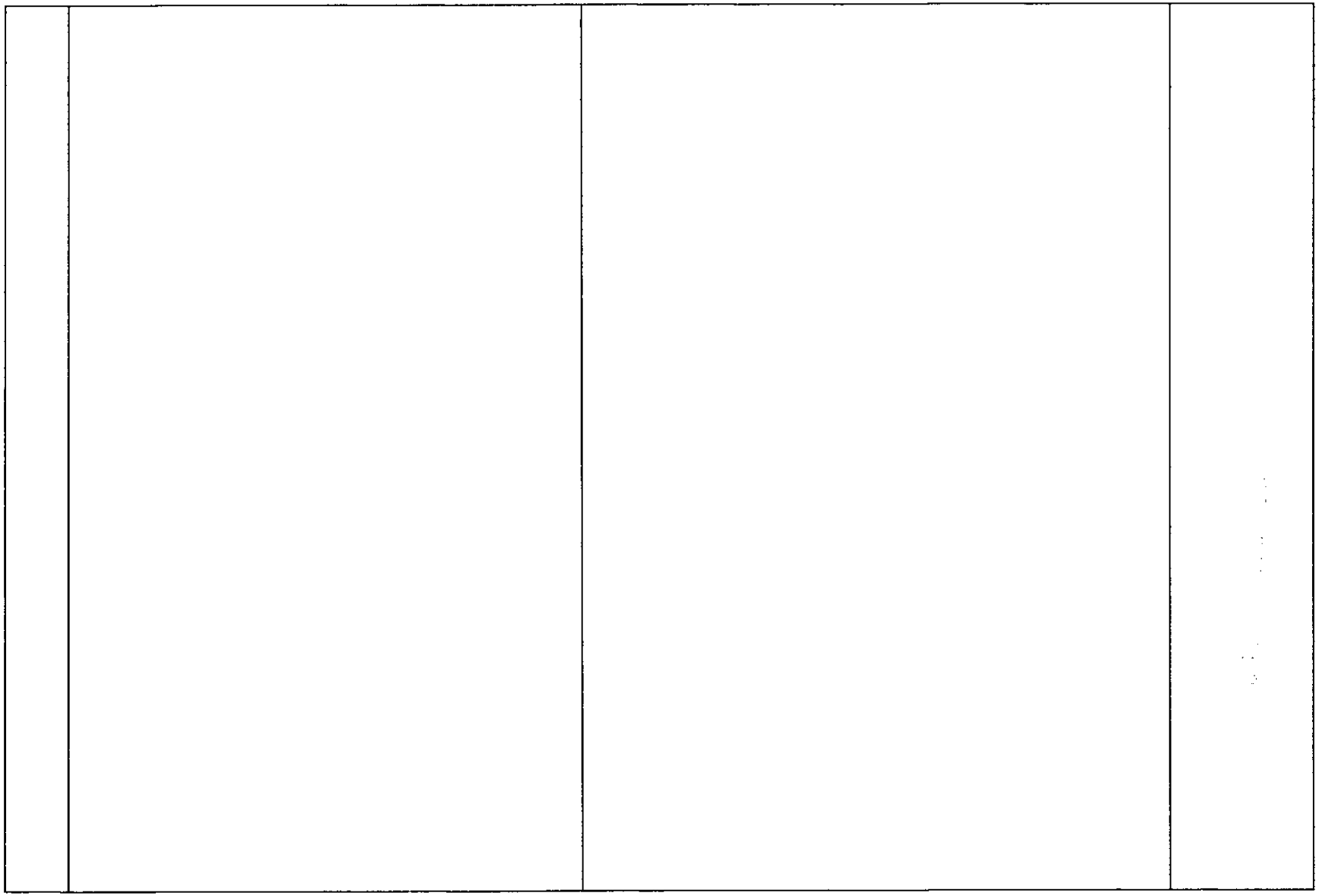
☒	§11-100.1-15 Medications. (e)
	All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.
	
	FINDINGS
	Resident #1 – Observed "Quetiapine fumurate 25mg tab, take 2 tablets by mouth for restlessness" in resident's medication bin. Original date filled was 8/21/2025. No physician or APRN order on file.
		PART 2
		
		FUTURE PLAN
		
		USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?
		
		Future Plan to Prevent Reoccurrence
		
		1. **Medication Admission & Verification Protocol**
		
		• For all residents, the Administrator or RN will verify **all medications** upon admission and each new refill against a written physician/APRN order.
		• Medications will not be entered into the MAR or administered until verified.
		
		2. **Monthly MAR Audit**
		
		• The Administrator will conduct **monthly audits of all MARs** to ensure:
		  o Each medication has a valid order
		  o Dose, route, and frequency match the order
		  o No unapproved medications are present
		• Findings will be documented in the **Medication QA Log**.
		
		3. **Staff Training & Competency**
		
		• All caregivers involved in medication administration will receive **quarterly refresher training** on:	

		○ Medication order requirements ○ MAR documentation ○ Facility policy for unapproved medications • Training acknowledgment forms will be maintained in personnel files. 4. **Administrator Oversight and Sign-Off** • The Administrator will sign off on all new or changed orders within **24 hours** of receipt. • This ensures any new medications are authorized before administration. 5. **Medication Storage and Bin Checks** • All resident medication bins will be **checked weekly** for compliance with authorized orders. • Unauthorized medications will be removed immediately and documented. 6. **Integration into QAPI Program** • Medication order compliance will be monitored monthly as a **QAPI performance indicator**. • Any discrepancies will trigger immediate corrective actions and staff retraining.	

	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.
	
	FINDINGS
	Resident #1 - Resident admitted 5/13/2025. The following medications are documented on the resident MARs: "Quetiapine fumarate 25mg tab, take ½ tablet by mouth every other day, (start date 1/1/2025)" "Senna 8.6mg tab, 1 tab PO daily, (start date 12/31/2024)" and "Fexofenadine 60mg tab, 1 tab PO BID (start date 8/5/2024)." Start dates do not have corresponding physician or APRN orders on file.
		PART 1
		
		DID YOU CORRECT THE DEFICIENCY?
		
		USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY
		
		I. PLAN OF CORRECTION (IMMEDIATE ACTIONS COMPLETED)
		
		1. Medication Orders Obtained and Filed
		
		• The Administrator contacted Resident #1's primary care provider and obtained **written physician/APRN orders**for:
		  ○ Quetiapine fumarate
		  ○ Senna
		  ○ Fexofenadine
		• Orders were faxed/securely received, printed, and placed in Resident #1's medical chart.
		• MAR was updated to reflect the correct order dates that match the provider's written orders.
		
		2. Medication Reconciliation Completed
		
		• A full medication reconciliation was performed comparing:
		  ○ the MAR
		  ○ the physician's orders
		  ○ medication labels
			9/27/2025

		○ pharmacy printouts • Any discrepancies were corrected immediately.	
		3. Review of All Resident Medication Orders • Administrator audited **all residents' medication charts** to verify that: ○ every medication on the MAR has a matching written order ○ start dates match the provider's documentation ○ all orders are signed, dated, and current • Missing or unclear orders were obtained and documented.	
		4. Staff Re-Education All PCGs/SCGs were reeducated on medication documentation standards: • No medication may be entered on the MAR **without a valid written physician/APRN order.** • Start dates must match the written order date. • Verbal orders must be authenticated in writing within the required timeframe. • Staff must notify the Administrator immediately if any medication lacks documentation. Signed training acknowledgment has been placed in staff files.	



	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. **FINDINGS** Resident #1 - Resident admitted 5/13/2025. The following medications are documented on the resident MARs: "Quetiapine fumarate 25mg tab, take ½ tablet by mouth every other day, (start date 1/1/2025)" "Senna 8.6mg tab, 1 tab PO daily, (start date 12/31/2024)" and "Fexofenadine 60mg tab, 1 tab PO BID (start date 8/5/2024)." Start dates do not have corresponding physician or APRN orders on file.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** **1. Medication Documentation Policy Reinforcement** A revised facility policy will ensure: • Written physician/APRN order **must be obtained before medication is administered.** • MAR entries must match the exact order details. • No medication will be transcribed based on bottle label alone. • All new orders and renewals will be verified by RN/Administrator before MAR entry. **2. New Admission Medication Verification Protocol** For every new resident: • A **Medication Admission Checklist** will be completed. • The Administrator will verify all medications with	

		the provider or pharmacy. • Written medication orders must be obtained **within 24 hours of admission**. • MAR will not be created until written orders are received. **3. Monthly Medication Chart Audits** The Administrator will conduct a **monthly audit of all resident MARs** to confirm: • all medications have corresponding written orders • orders are signed and dated • order renewal requirements are met • start dates are accurate Audit results will be entered into the **Medication QA Log**. **4. Quarterly Staff Training** Caregivers will receive quarterly refreshers on: • medication documentation requirements • proper MAR transcription • legal compliance regarding medication administration • identifying missing or outdated orders Training will be recorded in personnel files.	

5. Integration Into QAPI Program

Medication documentation accuracy will be added as a QAPI performance indicator:

- track number of discrepancies
- identify root causes
- implement corrective actions immediately
- review findings during monthly QAPI meetings

6. Provider Communication Protocol

A designated communication method (fax/secure email) will be used for:

- obtaining new orders
- requesting clarifications
- confirming changes

A log will be kept documenting every provider request and completion date.

7. MAR Entry Double-Check System

Before the MAR is finalized each month:

- Administrator and one caregiver will **double-check** each medication entry against the written orders.
- Any mismatch must be corrected before the new

		MAR is posted for use.	

	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. **FINDINGS** Resident #1 – License effective date 5/12/2025. Resident admitted on 5/13/2025. May 2025 MAR shows medications administered to resident from 5/1/2025 – 5/12/2025.	**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
☒	§11-100.1-15 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. **FINDINGS** Resident #1 – License effective date 5/12/2025. Resident admitted on 5/13/2025. May 2025 MAR shows medications administered to resident from 5/1/2025 – 5/12/2025.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** **1. Pre-Admission Licensing Verification Checklist** Before admitting any new resident, the Administrator must complete a **Licensure Verification Checklist** confirming: • Current license is active • License level matches the resident's level of care • Effective date of license precedes admission date • Admission packet may only be completed **after** license verification *No resident may be admitted if this checklist is incomplete.* This checklist will be filed in each resident's admission packet. **2. Mandatory MAR Start Date Review** • When creating a new MAR for an incoming resident, the Administrator will verify that the **MAR begins on the actual admission date**, never before. • A "MAR Start Date Verification" box has been added to the bottom of all new MAR templates. • Administrator will initial and date to confirm proper	

		start date before placing the MAR in use.
		
		3. Monthly Documentation Audit Under QAPI
		
		• This deficiency will be added to the **QAPI Documentation Audit Log**.
		• Administrator will review all new admissions monthly to ensure:
		  ○ no pre-admission documentation
		  ○ no entries made prior to license effective dates
		  ○ MARs align with actual admission dates
		• Any discrepancy will require immediate correction and additional staff training.
		
		4. Staff Orientation Update
		
		• All new staff will receive mandatory training during orientation regarding:
		  ○ legal consequences of providing care without a license
		  ○ prohibition of pre-license resident care
		  ○ proper MAR creation and date verification
		• Training will be repeated **semi-annually**.
		
		5. Admission Hold Procedure
		
		• A new procedure has been implemented: **"No resident may move in or receive services until the Administrator signs the Admission Authorization Form verifying active license status and resident eligibility."**
		
		This eliminates the possibility of pre-license care.	

6. Electronic Admission Log

- The facility has created an Admission Log to track:
  - date of contact
  - date of acceptance
  - date licensing verified
  - date of actual admission
- The log will help prevent early documentation entries and ensure compliance timelines.

7. Random Quarterly Review by Administrator

- Every quarter, the Administrator will select a random resident file to review:
  - MAR start dates
  - Admission dates
  - Treatment logs
  - Progress notes
- Findings will be documented in QAPI to ensure long-term compliance.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-15 Medications. (l)
	There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.
	
	FINDINGS
	Resident #2 – Observed "Refresh Tears" eye drops unsecured on bedside table.
		PART 1
		
		DID YOU CORRECT THE DEFICIENCY?
		
		USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY
		
		1. Immediate Removal and Securing of Medication
		
		• The "Refresh Tears" eye drops were **immediately removed** from the bedside table during inspection.
		• Medication was placed in the **locked medication storage cabinet**, as required by HAR 11-100.
		
		2. Verification of Resident Medication Storage Area
		
		• A complete audit of Resident #2's room and belongings was conducted to ensure:
		  ○ No other medication
		  ○ No OTC items
		  ○ No topical products
		  were left unsecured or accessible.
		• No additional unsecured medications were found.
		
		3. Facility-Wide Room Check Performed
		
		• All resident rooms were checked the same day to ensure **no unsecured medications** were present.
		• Documentation of room checks was filed in the facility's compliance log.
			9/12/2025

		4. Staff Re-Education on Medication Storage Policy
		• All PCGs and SCGs were reeducated on the requirement that:
		  ○ All medications **must remain secured** at all times.
		  ○ Residents may **not** keep medications at bedside unless:
		  ▪ A physician orders self-administration, and
		  ▪ A completed Self-Administration Assessment is on file.
		• Staff signed a **Medication Security Training Acknowledgment**.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications. **FINDINGS** Resident #2 – Observed "Refresh Tears" eye drops unsecured on bedside table.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** **1. Daily Medication Security Checks (New Procedure)** • Caregivers will perform daily room checks during morning care to ensure: ○ No medications, including drops, ointments, creams, or OTC items, are left out. • A checkbox for **"Medications Secured – Yes/No"** has been added to the **Daily Care Checklist**. **2. Weekly Administrator Room & Storage Audit** • The Administrator will conduct **weekly audits** of all resident rooms and common areas for unsecured medications. • Findings will be documented in the **Medication Security Audit Log**. • Non-compliance will result in immediate corrective action and staff retraining.	

		3. Medication Policy Revision & Posting
		
		The facility policy on medication security has been updated to include:
		
		• Clear instructions requiring that all medications remain secured when not in use.
		• Prohibition of storing any medication at bedside unless the resident is approved for self-administration.
		• Requirements for logging medications after every use.
		
		A copy of the updated policy will be posted in the medication area and staff office.
		
		4. Quarterly Staff Competency Validation
		
		• Every quarter, caregivers will undergo evaluation to demonstrate competency in:
		  ○ proper medication storage
		  ○ understanding self-administration rules
		  ○ documentation standards
		• Results will be kept in each employee's training file.
		
		5. Integration into QAPI Program
		
		• "Medication Security Compliance" is added to the **QAPI Performance Indicators**.
		• Monthly reporting will track:
		  ○ unsecured medication findings
		  ○ number of audits completed
		  ○ staff compliance trends	

		• Persistent issues will trigger corrective training or workflow changes.
		
		6. Resident Education (as applicable)
		
		• Residents capable of understanding safety instructions will be reminded:
		  ○ not to keep medications at bedside
		  ○ to notify staff if medication is dropped or misplaced
		• Education will be documented in the resident's progress notes.
		
		7. Updated Admission Process
		
		• During admission, staff will review:
		  ○ the facility's medication handling policy
		  ○ rules about self-administration and storage
		  ○ process for reporting misplaced medication
		• Resident and POA will sign acknowledgment.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-16 Personal care services. (h)
	A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed.
	
	FINDINGS
	Resident #5 – No documented evidence of a schedule of activities on file.
		PART 1
		
		DID YOU CORRECT THE DEFICIENCY?
		
		USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY
		
		1. Activity Schedule Created and Placed in Resident #5's Chart
		
		• A **personalized Monthly Activity Schedule** for Resident #5 was created based on:
		  ○ functional abilities
		  ○ cognitive level
		  ○ personal interests
		  ○ physician recommendations
		• The schedule includes daily and weekly activities such as:
		  ○ social activities
		  ○ cognitive stimulation
		  ○ mobility exercises
		  ○ sensory activities
		  ○ recreational and leisure options
		• The schedule has been filed in Resident #5's chart as required.
		
		2. Audit of All Resident Files Completed
		
		• Administrator reviewed all resident charts to ensure each contains:
		  ○ a **current Activity Schedule**
		  ○ an Activities Preference Survey, if applicable
			9/26/2025

		• Missing or outdated schedules were immediately updated and placed on file.
		
		3. Staff Re-Education on Documentation Requirements
		
		• All PCGs/SCGs were reeducated on HAR 11-100 requirements that:
		  ○ Each resident must have a **Schedule of Activities** on file.
		  ○ Activities offered and performed must align with documented schedules.
		• Staff signed the Activity Documentation Training Acknowledgment form.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-16 Personal care services. (h) A schedule of activities shall be developed and implemented by the primary care giver for each resident which includes personal services to be provided, activities and any special care needs identified. The plan of care shall be reviewed and updated as needed. **FINDINGS** Resident #5 – No documented evidence of a schedule of activities on file.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** **1. Monthly Activity Schedule Review Process** • At the beginning of each month, the Administrator will: o create or update each resident's **Monthly Activity Schedule**, o review it with caregivers, and o place a copy in each resident's chart and the activity binder. • Old schedules will be archived in the resident's file. **2. Updated Admission Packet Requirement** A Schedule of Activities will now be completed **within 72 hours of admission** and filed as part of the resident's admission documents. This ensures all new residents have an activity plan on file immediately. **3. Weekly Activity Implementation Check** • Administrator will conduct **weekly checks** to verify: o activities being offered match the schedule o participation or refusals are being	

		documented ○ schedule is being followed or adjusted as necessary • Findings will be recorded in the **Activity Compliance Log**. **4. Quarterly Staff Training on Activity Planning** Every quarter, caregivers will receive training on: • completing activity documentation • tailoring activities to resident needs • accurately recording participation and refusals • recognizing benefits of structured activities Training will be documented in personnel files. **5. Integration into QAPI Program** Activities documentation will be added to the QAPI indicators: • monthly audit of activity schedules • tracking compliance per resident • identification of trends or missed documentation • corrective action when needed **6. Resident Preference Assessment Updated Yearly** • Each resident's **Activity Preference Checklist** will be updated annually or sooner if functional or cognitive status changes. • Updated preferences will be reflected in the monthly schedule.	

		7. Backup System for Activity Schedule Completion • If the primary caregiver responsible for preparing the schedule is unavailable, the Administrator will complete the schedule to ensure no omissions occur. • This prevents gaps due to staff turnover or scheduling issues.	
		8. Activity Schedule Posted in Resident Areas • A general weekly activity board will be posted in the common area for residents and families. • This ensures transparency and consistency with the documented schedules.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(1) 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: Documentation of primary care giver's assessment of resident upon admission; **FINDINGS** Resident #4 – No documented evidence of an admission assessment completed during admission on file.	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
☒	§11-100.1-17 Records and reports. (a)(1) 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: Documentation of primary care giver's assessment of resident upon admission; **FINDINGS** Resident #4 – No documented evidence of an admission assessment completed during admission on file.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** 1. **Complete Missing Admission Assessment Immediately** o The Administrator and RN will complete Resident #4's admission assessment in full and place it in the resident's chart within **24 hours**. o All required sections—including medical history, functional status, ADLs, cognition, dietary needs, medication review, and safety risks—will be documented. 2. **Chart Audit for All Current Residents** o A full audit of all current residents' files will be conducted to ensure every resident has a completed admission assessment. o Any incomplete or missing forms will be completed and filed immediately. 3. **Staff Notification & Documentation** o All staff involved in admission processes will be advised of the deficiency and reminded of mandatory documentation requirements. o A copy of this Plan of Correction will be reviewed and acknowledged by staff.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(7) 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: Height and weight measurements taken; **FINDINGS** Resident #4 – No documented evidence of an admission height and weight on file for department review.	**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
☒	§11-100.1-17 Records and reports. (a)(7) 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: Height and weight measurements taken; **FINDINGS** Resident #4 – No documented evidence of an admission height and weight on file for department review.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** **1. Implement Mandatory Admission Vital Statistics Protocol** Effective immediately, the facility will require that **all admission assessments include:** • Height • Weight • Baseline vitals (BP, pulse, respirations, temperature) • BMI calculation • Date/time obtained • Name and signature of staff completing the measurement No admission packet will be considered complete until these items are collected and documented. **2. Create an Admission Checklist With Required Measurements** An updated **Admission Checklist** will list height and	

		weight as mandatory fields. • Admissions cannot be finalized until this checklist is completed and reviewed by the Licensee. • The checklist will be stored in the admission section of each resident's chart.	
		3. Staff Re-Training on Admission Requirements All caregiving staff responsible for admissions will receive re-training on: • Required components of a complete admission assessment • Correct height/weight measurement technique • Documentation protocols • Procedures for residents unable to stand (wheelchair scale, bed scale, alternative validated methods) Training will be completed **quarterly** and documented.	
		4. New "72-Hour Admission Review" Policy Within **72 hours of each new admission**, the Licensee will review the resident's chart to ensure: • Height and weight are documented • Measurements are recorded in the correct location • Data is entered in the vital signs log • Copies are included in the resident's care plan	

		Any missing measurements will be completed immediately.	
		5. Monthly Chart Audit for Height/Weight Documentation A monthly chart audit will be added to the facility's QAPI program to ensure: • All residents' admission packets contain height/weight • Measurements match the vital signs log • Any discrepancy is corrected within 24 hours Audit findings will be reviewed in the monthly QAPI meeting.	
		6. Coordination With PCP for Ongoing Monitoring The facility will ensure that every resident's height and weight are: • Updated annually during reassessment • Included in care plan updates • Communicated to the PCP when required for medication dosing, nutritional monitoring, or change-of-condition	

		7. Documentation Storage Improvement Admission height and weight will now be stored in **three accessible locations**: • Admission packet • Vital signs log • Care plan (if relevant to ADLs, nutrition, or safety) This redundancy ensures documentation is always available for OHCA review.	
		8. Administrator Oversight & Accountability The Licensee will personally verify: • New admissions include documented height/weight • Staff are trained and competent • Audits are consistent and signed monthly Steps taken will be documented to maintain continuous compliance.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-17 Records and reports. (a)(8)
	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:
	
	A current inventory of money and valuables.
	
	FINDINGS
	Resident #4 – Resident admitted on 9/1/2025. No documented evidence of an inventory of belongings done on admission.
		PART 1
		
		DID YOU CORRECT THE DEFICIENCY?
		
		USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY
		
		1. Immediate Correction Completed
		
		• On **Sept 26, 2025**, a complete **Resident Belongings Inventory** was conducted for Resident #4.
		• The inventory list was:
		  ○ Signed by the resident or responsible party
		  ○ Signed by the admitting caregiver
		  ○ Placed in the Admission Record section of the resident's chart
		  ○ A copy provided to the responsible party
		• Resident #4's belongings were verified and labeled as appropriate.
		
		2. Staff Re-Education
		
		• All caregivers and staff involved in the admission process were re-trained on the requirement that:
		  ○ **A belongings inventory must be completed at the time of admission,**
		  ○ Must include signatures,
		  ○ And must be filed in the chart before admission is marked complete.
		• Training completed on **[insert date]** and filed in the staff training binder.
			9/26/205

		3. Audit of All Current Residents • A facility-wide audit of all resident charts was completed on **[insert date]** to ensure belongings inventories exist for all residents. • Any missing or incomplete inventories were corrected immediately. **4. Responsible Person** • **Licensee/Administrator** • **Admission Coordinator (if applicable)** • **Primary Shift Caregiver on duty during admissions**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-17 Records and reports. (a)(8)
	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:
	
	A current inventory of money and valuables.
	
	FINDINGS
	Resident #4 – Resident admitted on 9/1/2025. No documented evidence of an inventory of belongings done on admission.
		PART 2
		
		FUTURE PLAN
		
		USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?
		
		1. Mandatory Admission Belongings Inventory Protocol
		
		• A **Belongings Inventory Form** will be completed for every new resident **at the time of admission**, without exception.
		• The form must be:
		  ○ Completed in full
		  ○ Signed by the caregiver and resident/POA
		  ○ Filed immediately in the chart
		• Admissions will not be considered complete until these steps are verified.
		
		2. Updated Admission Checklist
		
		• A revised **Admission Checklist** will include:
		  ○ Belongings inventory completed
		  ○ Signatures obtained
		  ○ Copy provided to resident/POA
		• The Licensee must review and sign off every completed checklist.
		
		3. Resident Item Labeling Procedure
		
		• All personal items (eyeglasses, clothing bags,	

		electronics, dentures, assistive devices, etc.) will be labeled or documented upon admission. • High-value items will require notation and may require POA acknowledgment. **4. Staff Training & Accountability** • Quarterly in-service training added to cover: o Proper belongings documentation o Handling of high-value items o Preventing lost or misplaced items • New hires will receive admission training on Day 1. **5. 72-Hour Admission Review** • Within **72 hours of every admission**, the Licensee will verify: o Belongings inventory is complete o Signatures are present o Form is filed in the chart o Copies distributed as required Any missing documentation will be corrected immediately. **6. Monthly QAPI Audits** • A monthly QAPI audit will include checking **Belongings Inventory documentation** for: o Completeness o Accuracy o Signatures o Chart placement • Any recurring issues will prompt additional staff	

		training and process updates.
		
		7. Secure Storage and Documentation System
		
		• Facility will maintain:
		  ○ A designated area for storage of resident valuables (if applicable),
		  ○ A logbook to document stored items,
		  ○ A release log when items are returned to the resident or family.
		
		8. Continuous Improvement
		
		• Belongings documentation will be reviewed during all:
		  ○ Care plan updates
		  ○ Room changes
		  ○ Discharges
		• Any policy gaps will be corrected immediately.
		
		Statement of Sustained Compliance
		
		The facility is committed to ensuring all admissions include a complete belongings inventory to protect resident property, prevent loss, and comply fully with OHCA requirements. Policies, trainings, and audit systems have been strengthened to prevent recurrence.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (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 – Resident's level of care evaluation dated 3/4/2025 on the "Resident Admission Medical and Personal History" form was documented as "ARCH." On the "Level of Care Evaluation for Adult Residential Care Home Residents" dated 3/4/2025, APRN evaluated resident needing extensive assistance and/or total assistance with 4 out of 6 ADLs scored. Observation of resident shows total assistance needed for resident to get out of and into bed/wheelchair via hoyer lift. Level of care evaluation not consistent. Must revaluate level of care.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** At the time of review, the level of care for **Resident #1** was determined to be **Expanded Adult Residential Care Home (E-ARCH)** due to a change in condition and increased care needs. A **family conference** was conducted with the resident's **Primary Care Provider (PCP)** and **Power of Attorney (POA)** to discuss the resident's condition and appropriate level of care. During the conference, the **POA requested additional time to identify and select an appropriate Expanded ARCH** placement for Resident #1. The facility continued to coordinate with the POA and PCP during this period while planning for a safe transition. Resident was discharged to an appropriate care home that is licensed and equipped to meet her assessed level of care needs.	10/1/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (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 – Resident's level of care evaluation dated 3/4/2025 on the "Resident Admission Medical and Personal History" form was documented as "ARCH." On the "Level of Care Evaluation for Adult Residential Care Home Residents" dated 3/4/2025, APRN evaluated resident needing extensive assistance and/or total assistance with 4 out of 6 ADLs scored. Observation of resident shows total assistance needed for resident to get out of and into bed/wheelchair via hoyer lift. Level of care evaluation not consistent. Must revaluate level of care.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** **Systemic Corrective Actions (To prevent similar documentation inconsistencies)** 1. **Standardized LOC Documentation Protocol**: o Effective immediately, the facility requires that **all LOC tools and admission forms use the same validated LOC instrument** or identical ADL scoring fields. No admission is complete until all LOC documentation is consistent and signed by the evaluating licensed clinician and the Administrator. 2. **Reconciliation Requirement**: o Upon completion of any LOC evaluation, the evaluating clinician must complete a **LOC Reconciliation Form** that: (a) confirms the LOC recorded on the Admission Medical History form matches the Level of Care Evaluation form, and (b) is co-signed by the Administrator/RN Supervisor before filing. 3. **Mandatory Clinician Verification**: o All LOC evaluations must be performed or co-signed by a licensed RN or APRN. Paper and electronic chart prompts will flag inconsistent entries for immediate review.	

		4. **Admission Hold Policy**: o Admissions will be placed on temporary hold if LOC documentation is incomplete or inconsistent. No resident will be accepted or retained until documentation is reconciled and approval provided by the Administrator/RN Supervisor. 5. **Hoyer/Transfer Competency Verification**: o Staff must demonstrate competency with mechanical lifts (Hoyer) in the competency log prior to performing transfers. Competency sign-offs will be maintained in personnel files. **3) Monitoring & Quality Assurance (How facility will ensure sustained compliance)** 1. **72-Hour Admission Review**: o The Administrator/RN Supervisor will review all new admissions within 72 hours to verify LOC documentation consistency, care plan alignment, and staff assignment for identified needs. 2. **Monthly LOC Documentation Audit**: o The RN Supervisor will perform monthly audits on a sample of resident charts (minimum 10% or at least 3 charts monthly) to verify LOC documentation consistency, accuracy of ADL scoring, reconciliation forms present, and care plan congruence. 3. **Incident Reporting & Trending**: o Any near-misses or incidents related to transfer or ADL care will be reported immediately and reviewed by QAPI. Trends	

will be analyzed quarterly.

4. **QAPI Review**:
   - LOC documentation compliance will be a standing item on the quarterly QAPI meeting agenda. Audit findings, corrective actions, and training needs will be documented and tracked until resolved.
5. **Annual Policy Review**:
   - Admission and LOC policies will be reviewed annually (or sooner if regulatory guidance changes) and updated accordingly.

4) Staff Education & Competency

1. **Immediate In-Service**:
   - All clinical staff were retrained on LOC assessment, accurate ADL scoring, required admission documentation, and the reconciliation process on **Oct 1, 2025**.
2. **Ongoing Training**:
   - LOC assessment training and Hoyer/transfer competency will be included in orientation for new clinical staff and as part of annual mandatory in-service training. Competency records will be maintained.
3. **Documentation Best Practices**:
   - Staff will be trained on documentation accuracy (timely entry, consistent scoring, sign-offs) and use of the LOC Reconciliation Form.

5) Responsible Persons

- **Primary Responsible:** Lea Cristobal Agpaoa, RN

		— Administrator (overall implementation, audits, QAPI reporting) • **Clinical Responsible:** RN Supervisor / APRN — LOC evaluations, clinician oversight, staff competency sign-offs • **Support:** Admissions Coordinator / designated staff — completing checklists and ensuring reconciliation prior to filing **6) Timeline & Dates of Completion** • Immediate re-evaluation and care plan revision completed on: **Nov. 20, 2025** • LOC Reconciliation Form and policy changes implemented: **Nov.20, 2025** • Staff in-service completed on: **Nov. 20, 2025** • 72-Hour Admission Review process effective immediately and ongoing. • Monthly audit schedule initiated on: **Oct. 1, 2025** • Full implementation of systemic measures complete by: **Nov 20, n2025— suggest within 30 days of POC submission]** **7) Documentation Attached (for OHCA review)** • Re-evaluation report dated **Nov. 20, 2025** signed by APRN/RN • Revised Care Plan for Resident #1 dated **[insert date]** • LOC Reconciliation Form signed **[insert date]** • Staff training roster and competency sign-offs dated **Nov. 20, 2025** • 72-Hour Admission Review log entry for Resident #1	

		Statement of Compliance The facility takes this finding seriously and has implemented immediate resident-level corrections, systemic process changes, staff training, and ongoing monitoring to ensure consistent and accurate Level of Care documentation and resident safety. The Administrator will provide OHCA with requested audit results and supporting documentation on follow-up inspection or upon request.	

	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; **FINDINGS** Resident #1, Resident #2, Resident #3 – Residents admitted in May 2025. No documented evidence of May 2025 progress notes on file.	**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
☒	§11-100.1-17 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; **FINDINGS** Resident #1, Resident #2, Resident #3 – Residents admitted in May 2025. No documented evidence of May 2025 progress notes on file.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** **1. Implementation of Monthly Progress Note Tracking System** • The facility will maintain a **Monthly Progress Note Log** listing each resident and the due date of their progress note. • This log will be completed and reviewed by the PCG at the beginning of every month. **2. Assignment of Responsibility** • The **PCG on duty** will be responsible for completing monthly progress notes for each resident. • The **Administrator / ARCH Licensee** will verify completion by the **last day of each month**. **3. Calendar-Based Reminder System** • A **physical calendar** will be posted in the medication room noting each resident's progress note due date. • A **digital reminder** will also be set on the Administrator's phone/email to alert the team one	

		week before the due date.
		
		4. Standardized Monthly Progress Note Template
		
		• A **facility-approved template** will be used to ensure consistent, complete documentation for all residents.
		• Template includes changes in condition, mobility, mood, ADLs, diet, behaviors, and incidents.
		
		5. Monthly Documentation Audit
		
		• Administrator will conduct a **monthly documentation audit** to ensure all required progress notes are completed and signed.
		• Findings will be recorded in the **QAPI Documentation Audit Log**.
		
		6. Staff Training
		
		• All caregivers will be **trained and re-educated** on:
		  ○ requirements for monthly progress notes
		  ○ importance of timely documentation
		  ○ use of the new progress note template
		• Training will be documented and kept in the facility training file.
		
		7. Immediate Correction Protocol for Missed Documentation
		
		• If a progress note is found missing after the end of the month, the Administrator will require completion within **24 hours**, along with a staff coaching form.	

		8. Quarterly QAPI Review • The facility will review documentation compliance quarterly through its **QAPI program**, identify patterns, and adjust processes as needed.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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	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: **FINDINGS** Resident #1 – No documented evidence of resident's response to diet documented on May 2025 – August 2025 progress notes on file.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** **Future Plan to Prevent Recurrence** **1. Monthly Documentation Review by Administrator** • At the end of each month, the Administrator will review all completed progress notes to ensure diet response is documented. • Any missing documentation will be corrected within **24 hours**, and staff will be coached using a written counseling form. **2. Standardized Documentation Tools** • The facility will maintain the newly created **Monthly Diet Response Section** in all resident progress notes. • A **Documentation Checklist** will be attached to each resident's monthly packet to ensure all required elements—including diet response—are completed. **3. Staff Training and Competency Verification** • All PCGs and SCGs will receive **annual documentation training** focusing on:	

		○ required elements of monthly progress notes ○ importance of documenting diet tolerance and intake ○ how diet response relates to resident safety and level of care • Competency checks will be conducted quarterly, and results will be filed in the training binder. **4. QAPI Monitoring** • The resident's diet documentation will be added to the facility's **QAPI tracking system**. • The Administrator will track compliance monthly and review trends quarterly. • If noncompliance is identified, the facility will revise processes or provide additional staff education. **5. Use of a Diet Monitoring Log (If Needed)** • If caregivers identify any decline in intake or changes in tolerance, a **Dietary Monitoring Log** will be initiated to track intake daily until stabilized. • This ensures more detailed monitoring for residents who may be at nutritional risk.	

	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; **FINDINGS** Resident #1 – No documented evidence of resident's response to medication documented on May 2025 – August 2025 progress notes on file.	**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
☒	§11-100.1-17 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; **FINDINGS** Resident #1 – No documented evidence of resident's response to medication documented on May 2025 – August 2025 progress notes on file.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** **1. Monthly Medication Response Section Added to Progress Notes** • The facility has implemented a **standardized Monthly Progress Note Template** with a required section titled: **"Resident Response to Medications / Effectiveness / Side Effects."** • This ensures caregivers document: o overall effectiveness o any adverse reactions o behavioral or physical changes o PRN medication effectiveness **2. Mandatory Monthly Review by Administrator** • At the end of every month, the Administrator will: o review all progress notes for completion o verify that medication response is documented o initial and date the progress note after review • Any missing documentation will be corrected within **24 hours**.	

3. Medication Monitoring Log for High-Risk or PRN Medications

- If a resident starts a new medication, changes dosage, or receives PRNs, the caregiver will complete a **Medication Monitoring Log**.
- This ensures consistent tracking of:
  - medication effects
  - changes in behavior
  - side effects
  - resident complaints
  - effectiveness of PRN medications

4. Staff Re-Education and Competency Checks

- All PCGs and SCGs will receive **annual training** on:
  - documenting medication response
  - identifying adverse reactions
  - notifying the licensed practitioner when needed
- The Administrator will perform **quarterly competency checks** to ensure understanding and compliance.

5. Monthly MAR and Progress Note Cross-Check

- Medication Administration Records (MARs) will be cross-checked with monthly progress notes to ensure documentation aligns with:
  - new medications
  - dosage changes

- PRN usage
- discontinued medications

- Any discrepancy triggers immediate corrective action.

6. QAPI Medication Documentation Tracking

- Medication-related documentation will be included in the **facility's QAPI tracking program**.
- Compliance will be reviewed monthly, and trends will be discussed quarterly.
- If repeated issues are identified, additional training or process modifications will be implemented.

7. Physician Notification Protocol

- If a caregiver observes any change in the resident's condition that may be related to medications, they must:
  1. Report immediately to the Administrator
  2. Document condition changes
  3. Notify the PCP or APRN if indicated
  4. Document response and new orders in the progress notes
- This ensures continuity of care and proper recording of changes.

8. Backup System for Documentation

- If the primary PCG is unavailable, a designated alternate PCG or Administrator will complete the **monthly medication response documentation**.
- This prevents missed months and ensures consistent reporting.

	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; **FINDINGS** Resident #1 – No documented evidence of resident's response to treatments documented on May 2025 – August 2025 progress notes on file.	**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
☒	§11-100.1-17 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; **FINDINGS** Resident #1 – No documented evidence of resident's response to treatments documented on May 2025 – August 2025 progress notes on file.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** **1. Required Monthly "Response to Treatments" Section Added to Progress Notes** • The facility has updated the **Monthly Progress Note Template** to include a mandatory section titled: **"Resident Response to Treatments (wound care, skin care, therapies, oxygen, exercises, etc.)"** • Caregivers must document: o whether the treatment was effective o changes in condition o improvement or decline o pain during or after treatment o resident cooperation or refusal o skin condition changes **2. Administrator Monthly Documentation Review** • At the end of each month, the Administrator will review all progress notes for completion. • If treatment response is missing, staff will be required to document it within **24 hours**. • Administrator will initial/date each completed and verified progress note.	

		3. Treatment Tracking Log for Ongoing Treatments
		• For any resident receiving ongoing or repetitive treatments (e.g., skin treatment, wound care, ROM exercises), a **Treatment Monitoring Log** will be used to record:
		  ○ each treatment provided
		  ○ resident response
		  ○ any noted changes
		  ○ caregiver observations
		• This forms the basis for a more accurate monthly summary.
		
		4. Staff Re-Education and Competency Validation
		• Caregivers will be reeducated on requirements to document treatment response in monthly progress notes.
		• Training will include how to identify:
		  ○ positive progress
		  ○ worsening symptoms
		  ○ new findings
		  ○ adverse reactions
		• Quarterly competency checks will be conducted and filed.
		
		5. Clear Protocol for Notifying Providers
		• Any decline or unexpected response to treatment will require immediate notification to:
		  ○ Administrator
		  ○ Provider (PCP or APRN) when warranted	

- Provider notifications will be documented in both the progress notes and the treatment log.

6. Monthly Treatment & Documentation Audit Through QAPI

- Treatment documentation will be monitored under the facility's **QAPI program**.
- Administrator will review compliance monthly and evaluate trends quarterly.
- Continued deficiencies will trigger additional staff training or revisions to workflow.

7. Cross-Checking Treatments With Orders

- The Administrator will cross-check:
  - treatment orders
  - MAR
  - treatment log
  - monthly progress notes
- This ensures that all ordered treatments have proper documentation, including response and outcomes.

8. Backup Documentation Plan

- If the primary caregiver responsible for treatments is unavailable, an alternate PCG or Administrator will complete the required monthly documentation.
- This prevents missed entries and ensures continuity.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(4) During residence, records shall include: Entries describing treatments and services rendered;" **FINDINGS** Resident #1, Resident #2, Resident #3, Resident #4, Resident #5 – No monthly "Resident Activity Record" documents describing treatments and services rendered from admission to September 2025, as of inspection 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

☒	§11-100.1-17 Records and reports. (b)(4)
	During residence, records shall include:
	
	Entries describing treatments and services rendered;"
	
	FINDINGS
	Resident #1, Resident #2, Resident #3, Resident #4, Resident #5 – No monthly "Resident Activity Record" documents describing treatments and services rendered from admission to September 2025, as of inspection 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?
		
		1. Monthly Activity Record Mandatory Checklist
		
		• Each resident will now have a **Monthly Resident Documentation Packet** that includes:
		  ○ Resident Activity Record
		  ○ Progress Notes
		  ○ Diet Response
		  ○ Treatment Response
		  ○ Weight Log (if applicable)
		• Staff must complete the Activity Record before the last day of the month.
		
		2. Administrator Monthly Documentation Audit
		
		• The Administrator will conduct a **monthly audit** of each resident's chart using a documentation checklist.
		• The Resident Activity Record must be:
		  ○ complete
		  ○ signed
		  ○ dated
		  ○ accurate
		• Missing documents will be corrected within **24**	

		hours and staff retrained if needed.
		
		3. Activity Record Log Added to QAPI Program
		
		• Activity documentation will be tracked in the **QAPI compliance log** monthly.
		• Trends or repeated non-compliance will prompt:
		  ○ additional training
		  ○ policy reminders
		  ○ workflow adjustments
		
		4. Standardized "Resident Activity Record" Template
		
		• A new, easy-to-use Activity Record form has been implemented.
		• The template includes required sections:
		  ○ ADLs completed
		  ○ treatments
		  ○ services rendered
		  ○ activities offered
		  ○ participation level
		  ○ refusals
		  ○ significant observations
		
		5. Caregiver Documentation Training (Quarterly)
		
		• All caregivers will undergo **quarterly documentation training**, including:
		  ○ how to complete the Resident Activity Record
		  ○ accuracy and timeliness expectations
		  ○ what qualifies as treatment or service
		• Competency checks will be performed quarterly.	

		6. Backup Documentation System
		
		• If the scheduled PCG fails to complete the Activity Record by the due date, the Administrator or alternate PCG will complete it.
		• This ensures no month is missed.
		
		7. Integration with Service Logs and Treatment Logs
		
		• The Activity Record will be cross-checked with:
		  o treatment monitoring logs
		  o MAR
		  o progress notes
		  o diet response logs
		• This ensures full alignment and accuracy of monthly documentation.
		
		8. Provider Notification Protocol
		
		• Any concerns about activity participation, refusal of treatment, or decline observed in Activity Records will trigger a notification to the Administrator and possibly the PCP/APRN.
		• These notifications will be documented in progress notes and activity logs.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(7) During residence, records shall include: Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency; **FINDINGS** Resident #1, Resident #2, Resident #3, Resident #5 – No weight measurement taken for August 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
☒	§11-100.1-17 Records and reports. (b)(7) During residence, records shall include: Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency; **FINDINGS** Resident #1, Resident #2, Resident #3, Resident #5 – No weight measurement taken for August 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?** **1. Monthly Weight Monitoring Protocol** A revised protocol will require: • All resident weights to be taken **during the first week of each month**. • The Administrator designates a primary staff member responsible for completing the monthly weights. • A secondary staff member will be assigned as backup to ensure no missed months due to staffing or scheduling issues. **2. Monthly Weight Log Binder Implemented** A **Monthly Weight Documentation Log** has been created and placed in the Medication/Clinical Binder. Log includes: • Resident name • Month and year • Date weight taken • Weight reading • Staff initials	

		• Notes (if weight unable to be obtained) The Administrator will review the log monthly to ensure completeness. **3. Weight Tracking Added to QAPI Program** Weight monitoring will be included as a QAPI performance indicator. • Each month, the Administrator will track weight documentation compliance. • Missing or late entries will trigger an internal corrective action. • Results will be reviewed during monthly QAPI meetings. **4. Staff Re-Education** All staff have been re-educated and will continue to be educated quarterly on: • Importance of monthly weight monitoring • Proper documentation requirements • Notification procedures if a resident refuses or is unable to be weighed • Reporting weight changes or abnormalities to RN/PCP immediately Training acknowledgment forms will be maintained in personnel files.	

5. Weight Measurement Reminder System

A two-step reminder system will be used:

1. **Calendar Reminder** – Monthly weight week will be marked on the facility calendar.
2. **Checklist Reminder** – The Administrator will distribute a "Monthly Task Checklist" at the start of each month listing weight monitoring as a required task.

6. Administrator Monthly Verification

The Administrator will perform a **final verification** by the 10th of each month to ensure:

- All residents' weights have been recorded
- Any exceptions (refusal, medical issue) are documented
- Weight trends are reviewed for potential concerns Findings will be documented on the Monthly Clinical Audit Form.

7. Annual Policy Review

The Weight Monitoring Policy will be reviewed annually and updated as needed to comply with OHCA standards and reflect best practices.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(8) During residence, records shall include: Notation of visits and consultations made to resident by other professional personnel as requested by the resident or the resident's physician or APRN; **FINDINGS** Resident #1 – Resident under hospice care. No documented evidence of any visits from hospice staff from either Bristol Hospice or in resident progress notes.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** **1. Immediate Audit and Correction** • The Administrator reviewed Resident #1's chart and identified missing hospice visit documentation. • Bristol Hospice was contacted to obtain all visit notes, nursing reports, aide notes, and interdisciplinary documentation for the periods of missing records. • All available hospice documentation has now been placed in Resident #1's chart under a dedicated **"Hospice Services"** section. **2. Staff Re-Education Completed** All staff involved in resident care were re-educated on the following: • Requirement that *every hospice visit* must be documented in the resident's progress notes. • Requirement to obtain copies of hospice documentation at each visit and file them immediately. • Procedure to notify the Administrator within 24	9/28/2025

		hours if hospice visits appear to be missed or undocumented.
		
		Staff signed acknowledgment forms, which have been filed in personnel records.
		
		3. Communication Re-Established With Hospice Agency
		
		• A direct communication line has been re-established with Bristol Hospice.
		• Hospice staff have confirmed they will:
		  o Provide visit notes electronically after each visit, **AND**
		  o Leave a physical copy in the facility binder during in-person visits.
		• A hospice binder has been placed in the medication room for all future hospice communication.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(8) During residence, records shall include: Notation of visits and consultations made to resident by other professional personnel as requested by the resident or the resident's physician or APRN; **FINDINGS** Resident #1 – Resident under hospice care. No documented evidence of any visits from hospice staff from either Bristol Hospice or in resident progress notes.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** **1. Hospice Visit Tracking Log Implemented** A **Hospice Visit Tracking Log** is now maintained in a separate binder. The log includes: • Date of scheduled visit • Name of hospice nurse/aide • Type of visit (RN check, aide care, chaplain, MSW, etc.) • Staff signature confirming visit occurred • Confirmation that visit note was filed Log is reviewed weekly by the Administrator. **2. Hospice Notes Added to Monthly Chart Audit** • Hospice visit documentation will be included in the **monthly chart audit** completed by the Administrator or designee. • Missing documentation will be addressed within 24 hours with the hospice agency.	

3. Progress Notes Updated Daily

Caregivers are now required to document in the daily progress notes:

- "Hospice visit completed today" and the name of the hospice staff
  OR
- "No hospice visit today – next scheduled visit on [date]"

This ensures continuity of care and creates a consistent documentation trail.

4. Quarterly Staff Training

Every quarter, caregivers will receive refresher training on:

- Hospice collaboration
- Documentation requirements
- Tracking, communication, and reporting
  Training logs will be maintained for QAPI review.

5. Hospice Coordination Meetings

The Administrator will conduct **quarterly coordination meetings** (virtual or in-person) with Bristol Hospice to ensure:

- Visit frequencies are being met
- Documentation is provided timely
- Any care plan changes are immediately communicated

Meeting notes will be included in QAPI records.

6. QAPI Integration

Hospice documentation compliance will be monitored as part of the facility's ongoing QAPI program.

- Monthly tracking
- Trend analysis
- Corrective actions, if needed

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-17 Records and reports. (h)(1)
	Miscellaneous records:
	
	A permanent general register shall be maintained to record all admissions and discharges of residents;
	
	FINDINGS
	No documented evidence of a permanent resident register maintained in the facility.
		PART 1
		
		DID YOU CORRECT THE DEFICIENCY?
		
		USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY
		
		1. Immediate Correction Completed
		
		• A **Permanent Resident Register** has now been created and implemented in the facility as of //2025.
		• The Administrator completed an audit of all current and past resident records and entered the following required information for each resident:
		  o Resident full name
		  o Date of birth
		  o Admission date
		  o Discharge date (if applicable)
		  o Discharge destination
		  o Responsible party/POA contact information
		• The register is maintained in a **dedicated binder labeled "Permanent Resident Register,"** stored in the administrative records section of the facility.
		
		2. Staff Re-Education Completed
		
		• All administrative and caregiving staff have been re-educated on the requirement to maintain a permanent resident register.
		• Training included:
		  o Purpose and regulatory requirement
		  o Information required to be captured
			9/26/2025

		○ Steps for updating the register during admission or discharge ○ Secure storage of the register • Staff signed training acknowledgment forms, which are now filed in personnel records.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-17 Records and reports. (h)(1)
	Miscellaneous records:
	
	A permanent general register shall be maintained to record all admissions and discharges of residents;
	
	FINDINGS
	No documented evidence of a permanent resident register maintained in the facility.
		PART 2
		
		FUTURE PLAN
		
		USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?
		
		1. Admission/Discharge Checklist Updated
		
		The **Admission Packet Checklist** and **Discharge Checklist** have been updated to include:
		
		• "Enter resident into Permanent Resident Register"
		• "Update discharge information in the Permanent Resident Register"
		
		This ensures that every new admission and every discharge triggers an update to the register **without exception**.
		
		2. Permanent Resident Register Audit Monthly
		
		• The Administrator will audit the register **monthly** to confirm:
		  ○ All residents currently admitted are listed
		  ○ All discharges are documented accurately
		  ○ All required fields are complete and up to date
		
		Monthly audit findings will be recorded on a **Resident Register Audit Log** and kept in the QAPI binder.	

		3. Register Included in QAPI Program
		
		• Compliance with maintaining the Permanent Resident Register is now part of the facility's **QAPI Tracking System**.
		• Any discrepancy or missed entry will result in immediate corrective action and staff retraining if needed.
		
		4. Secure Storage and Backup
		
		• The register will be kept in a locked administrative cabinet with restricted access.
		• A **digital backup** (password protected) will be maintained monthly to prevent loss of records due to damage or misplacement.
		
		5. Quarterly Staff Training
		
		• All administrative staff will undergo quarterly training on:
		  ○ Proper maintenance of the register
		  ○ Information accuracy
		  ○ Regulatory requirements
		  Training will be documented and stored in employee files.
		
		6. Administrator Oversight
		
		• The Administrator is responsible for ensuring continued compliance.
		• During monthly administrative meetings, maintenance of the Permanent Resident Register	

		will be reviewed and verified.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-17 Records and reports. (h)(1)
	Miscellaneous records:
	
	A permanent general register shall be maintained to record all admissions and discharges of residents;
	
	FINDINGS
	Observed documents relating to a resident discharge from the facility. Resident discharge not documented on a permanent resident register.
		PART 1
		
		DID YOU CORRECT THE DEFICIENCY?
		
		USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY
		
		1. Immediate Correction Completed
		
		• The Administrator reviewed the resident's discharge paperwork and immediately entered the following required information into the Permanent Resident Register:
		  ○ Resident's full name
		  ○ Admission date
		  ○ Discharge date
		  ○ Discharge destination (facility or home address)
		  ○ Responsible party/POA contact information
		• The Permanent Resident Register is now accurate and up to date as of //2025.
		
		2. Chart and Register Reconciliation Completed
		
		• A reconciliation of all active and discharged residents for the past 12 months was completed.
		• All missing discharge information (if any) was entered into the register to ensure full completeness and compliance.
			9/26/25

		3. Staff Re-Education Completed
		• All caregiving and administrative staff were re-educated on:
		  ○ The regulatory requirement for maintaining a complete Permanent Resident Register.
		  ○ The need to document **every admission and discharge** on the register immediately.
		  ○ How to properly complete and update the register.
		• Staff have signed training acknowledgment forms that have been placed in their personnel files.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date

☒	§11-100.1-17 Records and reports. (h)(1)
	Miscellaneous records:
	
	A permanent general register shall be maintained to record all admissions and discharges of residents;
	
	FINDINGS
	Observed documents relating to a resident discharge from the facility. Resident discharge not documented on a permanent resident register.
		PART 2
		
		FUTURE PLAN
		
		USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?
		
		Future Plan to Prevent Reoccurrence
		
		1. **Admission & Discharge Checklist Integration**
		
		• Admission and Discharge Checklists have been updated to include:
		  ○ **"Enter resident into Permanent Resident Register upon admission"**
		  ○ **"Update Permanent Resident Register upon discharge"**
		• Checklists must be completed and verified by the Administrator before admission/discharge is finalized.
		
		2. **Monthly Permanent Resident Register Audit**
		
		• The Administrator will perform a **monthly audit** of the register to verify all admissions and discharges are accurately documented.
		• Missing entries will be corrected within **24 hours**, and findings documented in a QA log.
		
		3. **Quarterly QAPI Review**	

		• Compliance with maintaining the Permanent Resident Register will be reviewed **quarterly** in QAPI meetings.
		• Trends, errors, or omissions will trigger corrective actions and staff retraining as necessary.
		
		4. **Staff Training & Competency**
		
		• Staff responsible for admission/discharge documentation will receive **quarterly refresher training**.
		• Training will include:
		  o Correct completion of the Permanent Resident Register
		  o Regulatory compliance expectations
		  o Verification procedures for admissions and discharges
		• Attendance and competency acknowledgment will be documented in personnel files.
		
		5. **Administrator Oversight & Sign-Off**
		
		• The Administrator will sign off on **every admission and discharge** within 48 hours to confirm:
		  o Completion of the Permanent Resident Register entry
		  o Accuracy of resident information
		  o Documentation of responsible party/POA and destination
		
		6. **Secure Storage and Backup**
		
		• The Permanent Resident Register will be stored in a **locked administrative file**.	

		• A **monthly digital backup** will be created to prevent loss due to damage or misplacement.	

Licensee's/Administrator's Signature: 

Print Name: Lea Cristobal Agpaoa

Date: Oct. 12, 2025

Licensee's/Administrator's Signature: _____

Print Name: LEA CRISTOBAL AGPAOA

Date: Oct 12, 2025