Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: My Kind Heart	**CHAPTER 100.1**
Address: **98-034 Kuleana Placa, Pearl City, Hawaii 96782**	**Inspection Date: March 25, 2025 Annual**

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS PER HAR 11-100.1-3(e)(2). IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

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

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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** Substitute caregiver (SCG) #3 – No current fingerprint background check clearance. Last completed 3/20/23. *Submit proof of correction with your plan of correction (POC).*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** SCG#3 is currently not working for me anymore so her documentations are no longer necessary.	09/04/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-3 Licensing. (b)(1)(1) 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** Substitute caregiver (SCG) #3 – No current fingerprint background check clearance. Last completed 3/20/23.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will make sure fingerprint documentations will be up to date by using Google Calendar with multiple advance notifications mirrored on my personal device with push notification reminders dating it to 2 months prior to expiration. Clearance letters will be stored in caregiver files. Caregivers will be taken off the schedule until renewed if documents are expired.	09/13/25

	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** SCG #2 - No documentation of initial (s-step skin test) tuberculosis (TB) screening. *Submit documentation with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, the deficiency has been corrected on April 15,2025. SCG#2 went to Lanakila to get documents of TB test screening.	09/04/25

	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** SCG #2 - No documentation of initial (2-step skin test) tuberculosis (TB) screening.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will utilize the new checklist for new caregivers as a requirement to include an initial 2-step TB test and attach it on their files. I will keep it at a 2 month in advance prior to avoid documentation lapses in the future.	08/27/25SC

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. **FINDINGS** SCG #1 – No record of training provided by the primary caregiver (PCG) to make medications available. *Submit documentation with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** SCG#1 training provided by the primary caregiver has been recorded. Will submit copy of documentation.	4/4/2025

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(4) The substitute care giver who provides coverage for a period less than four hours shall: Be trained by the primary care giver to make prescribed medications available to residents and properly record such action. **FINDINGS** SCG #1 – No record of training provided by the primary caregiver (PCG) to make medications available.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I have implemented a SCG training checklist that includes medication administration procedures and documentation for this requirement. The checklist will be signed by PCG and SCG at the time training is provided. I would use this checklist at on-boarding or monthly audits.	09/12/25

	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 #1 – No record of diet order since admission on 1/13/25. *Submit a copy with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** A diet order from Resident #1 was obtained from the residents physician and signed on 03/26/25. All new admissions will have a diet order obtained and filed within 24 hours. Annual diet orders will be tracked with reminders and resident files will be reviewed monthly to ensure documentation is current and complete.	08/27/251 w

	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 #1 – No record of diet order since admission on 1/13/25. *Submit a copy with your POC.*	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will make it my priority to utilize the diet checklist authorized by Physician/APRN and require it to be finished before admission is finalized. Verbal orders will also be noted on the order sheett signed by physician/APRN. I will not admit a resident without all necessary documents.	09/12/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 Food sanitation. (c) Refrigerators shall be equipped with an appropriate thermometer and temperature shall be maintained at 45°F or lower. **FINDINGS** The small refrigerator for snacks registered a temperature of 50° F, and the refrigerator in the kitchen for residents' foods registered a temperature of 60° F. Rechecked the thermometers after 2 hours, and the readings remained above 45°F.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I replaced the small refrigerator and adjusted the kitchen refrigerator at 45*F or lower.	08/27/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 Food sanitation. (c) Refrigerators shall be equipped with an appropriate thermometer and temperature shall be maintained at 45°F or lower. **FINDINGS** The small refrigerator for snacks registered a temperature of 50° F, and the refrigerator in the kitchen for residents' foods registered a temperature of 60° F. Rechecked the thermometers after 2 hours, and the readings remained above 45°F.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Refrigerator and freezer temperatures will be checked and logged twice daily to ensure they remain at 45*F or below. Any temperature above the standard will be addressed immediately by adjusting or servicing unit and discarding perishable items as needed. A maintenance log will be kept on file and the primary caregiver will review the logs weekly to ensure compliance.	08/27/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container. **FINDINGS** Liquid cough syrup was stored in a small refrigerator unsecured. Zylet eye drops were found on top of the small refrigerator.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I discarded the previous liquid cough syrup and replaced it with a new one to lower the risk of contamintaion and it is now secured completely in a locked fridge with the proper labels. The Zylet eye drops are now in the appropriate locked medication cabinet.	08/27/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container. **FINDINGS** Liquid cough syrup was stored in a small refrigerator unsecured. Zylet eye drops were found on top of the small refrigerator.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** All medications will be stored in a designated locked container or locked refrigerator as required. Staff will be trained that no medications will be left unsecured. A weekly check by the primary caregiver will be conducted to comply with security requirements.	08/27/25

	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 – The following medication orders dated 1/13/25 are incomplete – the dosage of medication to be administered, the route of administration, and specific instructions to use, including frequency of administration, were not included as follows: • 25-100 mg Carbidopa • 2.5 mg Nifedipine • 5 mg Propanolol • 5 mg Memantine • 2 Calcium pills • 1 or 2 stool softeners • Melatonin *Submit documentation of clarified medication orders with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, I have updated Resident#1's file that includes medication regimen, dosage instructions and administration details.	09/04/25

	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 – The following medication orders dated 1/13/25 are incomplete – the dosage of medication to be administered, the route of administration, and specific instructions to use, including frequency of administration, were not included as follows: • 25-100 mg Carbidopa • 2.5 mg Nifedipine • 5 mg Propanolol • 5 mg Memantine • 2 Calcium pills • 1 or 2 stool softeners • Melatonin	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** During daily chart reviews, i will check each residents physicians orders against MAR to verify order will include the name of medication, dosage, route, frequency and specific administration instructions, I will use a visual checklist to cue to that all orders are complete. If i noticed it's incomplete, I will not administer the medication until clarification is obtained. I will immediately notify the physician/APRN. Clarification must be obtained as soon as the incomplete order is identified.	09/12/25

	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 – Medications listed on the medication administration record (MAR) from January 2025 to present do not have physician orders. *Submit a copy of the signed physician orders and MARs for March and April 2025 with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency has been corrected. Physician orders for Resident #1 were obtained, reviewed and signed. The updated orders have been placed in the residents chart and the MAR was updated to reflect the signed physicians order.	08/27/25

	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 – Medications listed on the medication administration record (MAR) from January 2025 to present do not have physician orders.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** All the medications on the MAR will be cross-checked with signed physician orders before administration. Any missing or incomplete orders will be clarified immediately with the physician or APRN. The primary caregiver will review MARs and physician orders monthly to ensure they remain accurate and complete.	08/27/25

	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 – Pharmacy label/medication bottle and MAR do not match for the following medications: • MAR says Propanolol 10 mg po tab BID QD, but the medication label says Propanolol 5 mg give 0.25 tab BID. • MAR says Melatonin 10 mg po tab QD, but the bottle says 5 mg (over the counter) • MAR says, "Calcium 600 mg D3 10 mcg, but the bottle says Calcium 600 and D3 20 mcg (over the counter) *Submit a copy of the clarified orders and MARs for March and April with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The physicians were contacted and clarification orders were obtained for all medications in question. The MAR was updated to match the pharmacy label and physician orders. All corrected orders and MARs for March and April have been placed in the resident's file.	08/27/25

	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 – Pharmacy label/medication bottle and MAR do not match for the following medications: • MAR says Propanolol 10 mg po tab BID QD, but the medication label says Propanolol 5 mg give 0.25 tab BID. • MAR says Melatonin 10 mg po tab QD, but the bottle says 5 mg (over the counter) • MAR says, "Calcium 600 mg D3 10 mcg, but the bottle says Calcium 600 and D3 20 mcg (over the counter)	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Medication orders, pharmacy labels and the MAR will be cross checked upon admission and with each medication change to ensure accuracy. Any discrepancies will be clarified immediately with the physician/pharmacy. I will conduct a monthly audit of all MARs and medication labels to verify accuracy and compliance.	08/27/25A

	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 – Medication order for Midodrine HCL 2.5 mg give if SBP <169 was not given as instructed. • Medication was held on: 1/27/25 at 0600 for SBP 140, 1/28/25 at 1400 for SBP 99, and 1/30/25 at 1400 for SBP 102 • Medication was given on: 1/20/25 at 1400 for SBP 182, and 1/21/25 at 1400 for SBP 175	**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 #1 – Medication order for Midodrine HCL 2.5 mg give if SBP <169 was not given as instructed. • Medication was held on: 1/27/25 at 0600 for SBP 140, 1/28/25 at 1400 for SBP 99, and 1/30/25 at 1400 for SBP 102 • Medication was given on: 1/20/25 at 1400 for SBP 182, and 1/21/25 at 1400 for SBP 175	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** All staff will be retrained on the importance of following physician orders exactly as written, including hold parameters for medications. Blood pressure readings will be checked and documented before administering Midodrine and the medication will only be given according to the order. I will be checking with weekly vital signs to confirm compliance and accuracy.	08/27/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident #1 – No record of recent medical examination and current diagnosis within preceding 12 months of admission into facility on 1/13/25. *Submit a copy of the current physical exam with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Resident #1 was discharged and currently no longer under my care.	09/04/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident #1 – No record of recent medical examination and current diagnosis within preceding 12 months of admission into facility on 1/13/25.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** All new admissions will be required to have a current medical examination and diagnosis within the preceding 12 months on file prior to admission. A checklist will be utilized to confirm that all required records are obtained. I will review files quarterly to ensure medical exam records remain current and complete.	08/27/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(6) 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: Physician or APRN signed orders for diet, medications, and treatments; **FINDINGS** Resident #1 – No signed diet orders since admission on 1/13/25. *Submit documentation with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** A signed diet order for Resident #1 was obtained from the physician/APRN dated on 03/26/25 and placed in the residents chart. Documentation has been updated to ensure compliance.	08/27/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(6) 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: Physician or APRN signed orders for diet, medications, and treatments; **FINDINGS** Resident #1 – No signed diet orders since admission on 1/13/25.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** All residents will have a signed diet order obtained at admission and kept in their records. A tracking system with reminders will be used to ensure annual updates and I will review resident files monthly to confirm diet orders are current and signed.	08/27/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(6) 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: Physician or APRN signed orders for diet, medications, and treatments; **FINDINGS** Resident #1- No valid signed orders for medications and treatment orders since admission on 1/13/25. *Submit documentation of admission orders reflecting medications and treatment orders with your POC.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Resident #1 signed orders for medications and treatment orders already received on 03/26/25. It has already been placed on residents chart and documents have been updated to comply with admission requirements.	08/27/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(6) 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: Physician or APRN signed orders for diet, medications, and treatments; **FINDINGS** Resident #1- No valid signed orders for medications and treatment orders since admission on 1/13/25.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** All new admissions will have valid, signed physician or APRN orders for medications and treatments on file at the time of admission. A checklist will be used during intake to confirm all required documentation is obtained. I will review files monthly to ensure all orders remain current and properly signed.	08/27/25

	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 – No documentation of compression stockings application due to history of low blood pressure.	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 – No documentation of compression stockings application due to history of low blood pressure.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Verified with Resident #1's physician/APRN that compression stockings remain an active treatment due to low blood pressure, Usage of compression stockings will now be documented in the Treatment Record and/or MAR under treatments with the same level of detail and consistency as medications including frequency, time of application and signed by providing caregiver.	09/12/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary. **FINDINGS** Resident #2 – No incident report was generated following hospitalization on 6/23/24 due to pneumonia.	**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. (c) Unusual incidents shall be noted in the resident's progress notes. An incident report of any bodily injury or other unusual circumstances affecting a resident which occurs within the home, on the premises, or elsewhere shall be made and retained by the licensee or primary care giver under separate cover, and shall be made available to the department and other authorized personnel. The resident's physician or APRN shall be called immediately if medical care may be necessary. **FINDINGS** Resident #2 – No incident report was generated following hospitalization on 6/23/24 due to pneumonia.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I emphasize to all staff and myself that all hospitalizations, minor and major injuries and unusual incidents will be documented immediately with a completed incident report and progress note. I will review incident logs weekly to ensure compliance and safety.	08/27/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
		PART 1	
☒	§11-100.1-17 Records and reports. (f)(4) General rules regarding records: All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency. **FINDINGS** Resident #2 – Discharge summary report following hospitalization on 6/23/24 unavailable for review.	**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. (f)(4) General rules regarding records: All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency. **FINDINGS** Resident #2 – Discharge summary report following hospitalization on 6/23/24 unavailable for 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?** All hospital discharges will require a summary report to be obtained from the facility before the resident returns. The discharge summary will be filed in the residents charts immediately upon receipt. I will review records weekly to confirm all hospital visits and discharges have complete documentation on file.	08/27/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (g) All information contained in the resident's record shall be confidential. Written consent of the resident, or resident's guardian or surrogate, shall be required for the release of information to persons not otherwise authorized to receive it. Records shall be secured against loss, destruction, defacement, tampering, or use by unauthorized persons. There shall be written policies governing access to, duplication of, and release of any information from the resident's record. Records shall be readily accessible and available to authorized department personnel for the purpose of determining compliance with the provisions of this chapter. **FINDINGS** Resident #1 – Whiteout was used on January 2025 BP logs.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The January 2025 BP log was re-done to accurately reflect the readings without alteration. Staff were instructed that whiteout or erasures are not permitted on any resident records and corrections must be made by drawing a single line through the error, initialing and dating the correction.	08/27/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (g) All information contained in the resident's record shall be confidential. Written consent of the resident, or resident's guardian or surrogate, shall be required for the release of information to persons not otherwise authorized to receive it. Records shall be secured against loss, destruction, defacement, tampering, or use by unauthorized persons. There shall be written policies governing access to, duplication of, and release of any information from the resident's record. Records shall be readily accessible and available to authorized department personnel for the purpose of determining compliance with the provisions of this chapter. **FINDINGS** Resident #1 – Whiteout was used on January 2025 BP logs.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** All staff will follow proper correction procedures when documenting resident records. Training will be reinforced on how to correct errors appropriately. I will review records weekly to ensure that no unauthorized alterations were made.	08/27/25

Licensee's/Administrator's Signature: _____

Print Name: Imelda P. Hyde

Date: 08/29/2025

Licensee`s/Administrator`s Signature: _____

Print Name: Imelda Hyde

Date: 09/13/2025