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STATE OF HAWAII
DEPARTMENT OF HEALTH

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Nabua Quality Care Home II	CHAPTER 100.1
Address: 94-531 Awanoi Street, Waipahu, Hawaii 96797	Inspection Date: May 30, 2025 Initial 6-month inspection

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

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

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

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>, (b)(1)(I) Application.</p> <p>In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application:</p> <p>Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law;</p> <p>FINDINGS Primary Care Giver (PCG), Substitute Care Giver (SCG) #1, SCG #2 -- No current documented evidence that aforementioned care givers have no prior felony or abuse convictions in a court of law on file for department review.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I have obtain and now have current document for myself (PCG), Substitute Care Giver (SCG) # 1, SCG # 2 and place it into my Care Home binder.</p>	<p>6.2.25</p>

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6.2.25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-3 <u>Licensing</u>. (b)(1)(I) Application.</p> <p>In order to obtain a license, the applicant shall apply to the director upon forms provided by the department and shall provide any information required by the department to demonstrate that the applicant and the ARCH or expanded ARCH have met all of the requirements of this chapter. The following shall accompany the application:</p> <p>Documented evidence stating that the licensee, primary care giver, family members living in the ARCH or expanded ARCH that have access to the ARCH or expanded ARCH, and substitute care givers have no prior felony or abuse convictions in a court of law;</p> <p><u>FINDINGS</u> PCG, SCG #1, SCG #2 – No current documented evidence that aforementioned care givers have no prior felony or abuse convictions in a court of law on file for department review.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening again, in the future I will check and review all document being submitted including myself (PCG) to ensure it has been added into my Care Home Binder. Also I will send out reminders to all caregivers including me (PCG) at least 3 months ahead before requirements / certificate expiration date.</p>	<p style="text-align: center;">6.2.25</p> <p style="text-align: center;">25 MIG 14</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><u>FINDINGS</u> SCG #1, SCG #4 – No documented evidence that PCG trained aforementioned care giver to make prescribed medications available to residents and properly record such action, on file.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I have provide the training documents for substitute #1 and substitute #4 to make prescribed medication available to residents and now have training documents being recorded and have then signed the training form.</p>	<p>6.5.25</p>

25 JUL -1 AM:28

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(4) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be trained by the primary care giver to make prescribed medications available to residents and properly record such action.</p> <p><u>FINDINGS</u> SCG #1, SCG #4 – No documented evidence that PCG trained aforementioned care giver to make prescribed medications available to residents and properly record such action, on file.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>In the future, to prevent this from happening, I will check and review monthly to ensure all substitute training form has been documented. I use new substitute checklist to remind myself to train substitutes.</p>	<p style="text-align: center;">6.5.25</p>

25 JUL -7 10:28

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(2) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:</p> <p>Be able to provide personal care to the residents, including bathing, dressing, transferring, feeding, and transporting residents, and be able to provide care as stipulated in the schedule of activities or care plan;</p> <p><u>FINDINGS</u> SCG #1 – No documented evidence that PCG trained aforementioned care giver to Be able to provide personal care to the residents, including bathing, dressing, transferring, feeding, and transporting residents, and be able to provide care as stipulated in the schedule of activities or care plan, on file.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I have provide the training documents for substitute #1 to provide personal care to the residents, including bathing, dressing, transferring, feeding, and transporting residents, and be able to provide care as stipulated in the schedule of activities or care plan, and now being filed in my care Home binder and have then signed the training form.</p>	<p>6.5.25</p> <p style="text-align: right;">JUL 7 1998</p>

25 JUL -7 1998

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(2) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:</p> <p>Be able to provide personal care to the residents, including bathing, dressing, transferring, feeding, and transporting residents, and be able to provide care as stipulated in the schedule of activities or care plan;</p> <p><u>FINDINGS</u> SCG #1 – No documented evidence that PCG trained aforementioned care giver to Be able to provide personal care to the residents, including bathing, dressing, transferring, feeding, and transporting residents, and be able to provide care as stipulated in the schedule of activities or care plan, on file.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening again. I will check and review monthly to ensure all substitute training form has been documented. & will use substitute checklist to remind myself to train substitutes.</p>	<p>6.5.25</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (a) Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be obtained prior to a resident's admission to a Type I ARCH and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's responsible placement agency, and others authorized by the resident to review it.</p> <p>FINDINGS Resident #2 – Resident admitted on 5/9/2025. Facility received level of care determination by resident's physician on 5/27/2025. No documented evidence of an admission level of care evaluation by a physician or advanced practice registered nurse (APRN) prior to admission.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I now have a copy of the level of care form for residents #2 & filed into the residents binder.</p>	<p style="text-align: right;">6. 6. 25</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (a) Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be obtained prior to a resident's admission to a Type I ARCH and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's responsible placement agency, and others authorized by the resident to review it.</p> <p><u>FINDINGS</u> Resident #2 – Resident admitted on 5/9/2025. Facility received level of care determination by resident's physician on 5/27/2025. No documented evidence of an admission level of care evaluation by a physician or APRN prior to admission.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>In the future, to prevent this from happening, I will use Care Home check list provided by DDH to remind me on the day of admission. I will obtain a copy of all required documents from the residents for admission.</p>	<p style="text-align: right;">6-6-25</p> <p style="text-align: right;">JUL 7 11:00 AM '25</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition</u>. (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.</p> <p><u>FINDINGS</u> Resident #2 – Resident admitted on 5/9/2025. Facility received admission diet order on 5/27/2025. No documented evidence of an admission diet order on admission by a physician or APRN.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>I have obtain a copy of diet order for residents A2 and now have place a document inside the resident's chart.</i></p>	<p style="text-align: center;"><i>6. 6. 25</i></p> <p style="text-align: center;">STY JUN 21 11:29 AM '25</p>

25 JUL -7 11:28

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (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.</p> <p>FINDINGS Resident #2 – Resident admitted on 5/9/2025. Facility received admission diet order on 5/27/2025. No documented evidence of an admission diet order on admission by a physician or APRN.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening, in the future - I will use a Care Home checklist provided by DOH to remind me on the day of admission. I will obtain a copy of all documents required from the residents admission.</p>	<p style="text-align: right;">6.6.25</p> <p style="text-align: right;">JUL -7 8:28</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation</u>, (d) Potentially hazardous food shall meet proper temperature requirements during storage, preparation, display, service, and transportation.</p> <p>FINDINGS Observed opened, expired package of fresh saimin with expiration date of 5/10/2025 in refrigerator.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I have removed the expired package of fresh saimin out of the fridge during the inspection.</p>	<p>6-1-25</p> <p style="text-align: right;">SIA C. L. L.</p>

25 JUL -7 09:28

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (d) Potentially hazardous food shall meet proper temperature requirements during storage, preparation, display, service, and transportation.</p> <p><u>FINDINGS</u> Observed opened, expired package of fresh saimin with expiration date of 5/10/2025 in refrigerator.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening, everyday I will check the fridge to make sure there is no item expiring or expired inside the fridge. Also I will make a note as a reminder to all caregivers and post it in the fridge.</p> <p style="text-align: right;">STATE LIC. DIV.</p>	<p style="text-align: center;">6-1-25</p> <p style="text-align: center;">25 AUG 14</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p>FINDINGS Resident #1 – Physician ordered “Trazadone 50mg tablet, 1 tablet by mouth at bedtime. May take 3 tabs as needed.” Medication bottle label reads “Trazadone 50mg tablet, take 1-2 tablets by mouth every evening.” Physician order does not match medication bottle label.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I now have the Trazadone 50mg tablet labeled on the medication bottle for resident #1 matches from the physician's order.</p>	<p style="text-align: center;">6. 20. 2025</p> <p style="text-align: right;">STAFF CARELL</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (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.</p> <p>FINDINGS Resident #1 – Physician ordered “Trazadone 50mg tablet, 1 tablet by mouth at bedtime. May take 3 tabs as needed.” Medication bottle label reads “Trazadone 50mg tablet, take 1-2 tablets by mouth every evening.” Physician order does not match medication bottle label.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>In the future, to prevent from happening again, when I receive physicians order, I will double check the label on the medication bottle to ensure that they both matched. I will make a reminder note inside my care home binder.</p>	<p>6-20-2025</p> <p style="text-align: right;">STATE OF CONNECTICUT DEPT. OF SOCIAL SERVICES</p>

25 JUL -7 A9:28

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p>FINDINGS Resident #1 – Physician ordered “Quetiapine Fumarate 50mg tablet every morning, 100mg every bedtime.” Medication bottle label reads “Quetiapine Fumarate 100mg tablet, take 1 tablet by mouth every day in the evening.” Physician order does not match medication bottle label.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;">The Quetiapine Fumarate 50mg tablet labeled on the medication bottle for resident #1. Now, matches from physicians order.</p>	<p style="text-align: center;">6-21-25</p> <p style="text-align: center;">STATE: MI DATE: 6/21/25</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (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.</p> <p>FINDINGS Resident #1 – Physician ordered “Quetiapine Fumarate 50mg tablet every morning, 100mg every bedtime.” Medication bottle label reads “Quetiapine Fumarate 100mg tablet, take 1 tablet by mouth every day in the evening.” Physician order does not match medication bottle label.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening again when I receive physicians order. I will double check the label on the medication bottle to ensure that they both matched. I will make a reminder note inside my Care Home Binder.</p>	<p style="text-align: right;">6.21.25</p> <p style="text-align: right;">STATE LIC. REC.</p>

25 JUL -7 19:28

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p>FINDINGS Resident #1 – “Trazadone 50mg, 1 tablet by mouth at bedtime” and “Quetiapine Fumarate 100mg every bedtime” were both scheduled to be administered at 1900 on the May 2025 medication administration record (MAR). Inspection conducted in the morning hours. PCG initialed on May 30th that the aforementioned medications that were scheduled for 1900, were already administered.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;"><i>I now administer and initial only on the time it was given each medication.</i></p>	<p style="text-align: center;"><i>6.1.25</i></p> <p style="text-align: center;">STATE OF MICHIGAN STATE HEALTH DEPARTMENT</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident.</p> <p><u>FINDINGS</u> Resident #1 – "Trazadone 50mg, 1 tablet by mouth at bedtime" and "Quetiapine Fumarate 100mg every bedtime" were both scheduled to be administered at 1900 on the May 2025 medication administration record (MAR). Inspection conducted in the morning hours. PCG initialed on May 30th that the aforementioned medications that were scheduled for 1900, were already administered.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>In the future, I will care fully initial each medication right after the medication has been administer. Also, I will keep a reminder note inside my Care Home Binder.</p>	<p style="text-align: right;">6-1-25</p> <p style="text-align: right;">STATE OF CONNECTICUT JUL 7 11</p>

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STATE LICENSING

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-16 <u>Personal care services.</u> (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.</p> <p>FINDINGS Resident #1, Resident #2 -- No documented evidence of a plan of care on admission, on file for department review.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I have completed the Plan of care on admission for resident #1 and resident #2 and now, it's inside the residents binders.</p>	<p>6-2-25</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-16 <u>Personal care services.</u> (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.</p> <p><u>FINDINGS</u> Resident #1, Resident #2 – No documented evidence of a plan of care on admission, on file for department review.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>To prevent this from happening. In the future, I will use a Care Home checklist provided by DOH to remind me on the day of admission to complete a plan of care for the resident.</p>	<p style="text-align: center;">6-2-25</p> <p style="text-align: center;">STATE OF CONNECTICUT DEPARTMENT OF HUMAN SERVICES</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-21 <u>Residents' and primary care givers' rights and responsibilities.</u> (a)(1)(C) Residents' rights and responsibilities:</p> <p>Written policies regarding the rights and responsibilities of residents during the stay in the Type I ARCH shall be established and a copy shall be provided to the resident and the resident's family, legal guardian, surrogate, sponsoring agency or representative payee, and to the public upon request. The Type I ARCH policies and procedures shall provide that each individual admitted shall:</p> <p>Be fully informed orally and in writing, prior to or at the time of admission, and during stay, of services available in or through the Type I ARCH and of related charges, including any charges for services not covered by the Type I ARCH's basic per diem rate;</p> <p>FINDINGS Resident #2 – Signed General Operating Policy (GOP) did not include Type I ARCH monthly charges, and any related charges, including any charges for services not covered by the Type I ARCH's basic per diem rate.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>On the day of inspection. I added the monthly charges into the (GOP) General Operating Policy for resident # 2 and how it's inside the residents chart.</p>	<p>S. 30.25</p> <p style="text-align: right;">STATE LIBRARY JUL 9 1994</p>

25 JUL -7 19:29


	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-21 <u>Residents' and primary care givers' rights and responsibilities.</u> (a)(1)(C) Residents' rights and responsibilities:</p> <p>Written policies regarding the rights and responsibilities of residents during the stay in the Type I ARCH shall be established and a copy shall be provided to the resident and the resident's family, legal guardian, surrogate, sponsoring agency or representative payee, and to the public upon request. The Type I ARCH policies and procedures shall provide that each individual admitted shall:</p> <p>Be fully informed orally and in writing, prior to or at the time of admission, and during stay, of services available in or through the Type I ARCH and of related charges, including any charges for services not covered by the Type I ARCH's basic per diem rate;</p> <p><u>FINDINGS</u> Resident #2 – Signed General Operating Policy (GOP) did not include Type I ARCH monthly charges, and any related charges, including any charges for services not covered by the Type I ARCH's basic per diem rate.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>In the future, to prevent this from happening, I will create a checklist of requirement, including Type I ARCH monthly charges and any related charges that need to be completed before starts of services. Also, I will provide copies to all parties legally involved with resident's well being.</p> <p style="text-align: right;">STATE LICENSING</p>	<p style="text-align: center;">5.30.25</p> <p style="text-align: right;">25 AUG 1.</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(I) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either:</p> <p>FINDINGS Resident #2 – Resident admitted on 5/9/2025. Facility received admission self-preservation determination on 5/27/2025. No documented evidence of an admission self-preservation evaluation on by a physician or APRN on admission.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p style="text-align: center;">I now have a copy of a self-preservation document for resident #2 and now, it's inside the residents chart with the physicians signature.</p>	<p style="text-align: center;">6-225</p> <p style="text-align: center;">STATE LICENSING</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment</u>. (g)(3)(I) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either:</p> <p><u>FINDINGS</u> Resident #2 – Resident admitted on 5/9/2025. Facility received admission self-preservation determination on 5/27/2025. No documented evidence of an admission self-preservation evaluation on by a physician or APRN on admission.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>In the future, to prevent this from happening again. On the day of admission - I will carefully check each document required by DDH to ensure I have all the copy for self-preservation form and sign by the physician.</p>	<p>6-2-25</p> <p style="text-align: center;">OFFICE OF STATE LICENSING</p>

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Licensee's/Administrator's Signature: 

Print Name: LIEA N. NABUA

Date: July 3, 2025

STATE

STATE LICENSING

25 JUL -7 09:29

Licensee's/Administrator's Signature: *[Signature]*

Print Name: LIFA N. KABWA

Date: 8-14-2025

25 AUG 14 2025
STATE LIC ADMIN