Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Olalani Senior Care, LLC	**CHAPTER 100.1**
Address: **45-217 William Henry Road, Kaneohe, Hawaii 96744**	**Inspection Date: April 3, 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. 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
☒	§11-100.1-2 Definitions. As used in this chapter: "Self preservation" means the ability of an ARCH or expanded ARCH resident to ambulate without physical assistance, and the ability of the resident to follow directions and take appropriate action in exiting an ARCH or expanded ARCH in the event of an emergency. **FINDINGS** Resident #2 – Resident's self-preservation statement dated 6/24/24 (evaluated as self-preserving), does not reflect resident's current status. Resident does not meet the definition of self-preservation. Submit an updated self-preservation evaluation signed and completed by physician with plan of correction. Do not pre-fill/complete form for physician.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. Made an appointment with Resident #2's PCP to re-evaluate resident's 'Self Preservation's Form status.' Resident was brought to PCP's clinic and discussed present status of her client. Resident was examined and re-evaluated by PCP. ('Self-Preservation Form and PCP's doctor's notes attached)	04/23/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-2 Definitions. As used in this chapter: "Self preservation" means the ability of an ARCH or expanded ARCH resident to ambulate without physical assistance, and the ability of the resident to follow directions and take appropriate action in exiting an ARCH or expanded ARCH in the event of an emergency. **FINDINGS** Resident #2 – Resident's self-preservation statement dated 6/24/24 (evaluated as self-preserving), does not reflect resident's current status. Resident does not meet the definition of self-preservation. Submit an updated self-preservation evaluation signed and completed by physician with plan of correction. Do not pre-fill/complete form for physician.	**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.Had an in-service with staff of deficiency. Self-Preservation Form reviewed and discussed. PCG and staff familiarized themselves with Chapter 11-100.1 Certification of a resident in a Type I ARCH by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions. (11-100.1-23 (g)(3)(1). The above was discussed extensively. 2. Informed staff that the 'Self-Preservation Form' must be filled out by the Physician or APRN. The care home may provide the blank form to the PCP to be filled out by him/her and must be completed and signed by the PCP/PA/APRN. Do not prefill the boxes.	04/23/25

	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** SCG #1 – Two (2) consecutive years of Fieldprint clearances unavailable SCG #1,2 – Current Fieldprint clearance unavailable Submit a copy of current Fieldprint clearances with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. PCG located all the necessary forms and certificates to include Field Print clearances necessary for employment to Olalani Senior Care, LLC from the Care Home Folder of Hokulaki Senior Living, LLC where SGs #1, 2 mainly work as caregivers. Forms, Certificates and Clearances were copied and placed in the Olalani Senior Care Home Folder. (Copy of Field Print Clearances Attached)	04/09/25

	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** SCG #1 – Two (2) consecutive years of Fieldprint clearances unavailable SCG #1,2 – Current Fieldprint clearance unavailable Submit a copy of current Fieldprint clearances with plan of correction.	**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. Had a meeting with Staff and reviewed the 'Personnel Form' created for all employees to track down all necessary paperwork needed for the Annual Inspection, which includes Field Print Clearances. 2. PCG or designated substitute will be in-charged of checking the Field Print clearances if done on the designated year it has to be done for accuracy and completeness. Field Print clearances will also be checked of their presence in the Olalani Care Home Folder every 6 months and randomly to check for dates of employee clearances to avoid missed due dates of clearances.	04/09/25

	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** Substitute Caregiver (SCG) #1 – Current physical exam unavailable Submit a copy with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. PCG located all the necessary forms and certificates to include current Physical Exam necessary for employment to Olalani Senior Care, LLC from the Care Home Folder of Hokulaki Senior Living, LLC where SGs #1 mainly work as a caregiver. Annual Physical Exam was copied and placed in the Olalani Senior Care Home Folder. (Copy of Physical Exam Attached)	04/09/25

	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** Substitute Caregiver (SCG) #1 – Current physical exam unavailable Submit a copy with plan of correction.	**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.Had a meeting with Staff and reviewed the 'Personnel Form' created for all employees to track down all necessary paperwork needed for the Annual Inspection, which includes Annual Physical Exam. 2. PCG or designated substitute will be in-charged of checking the Employees' Annual Physical Exam every 3-6 months for the review of next due date of P.E. and to make sure that the form has been filled out completely by the PCP/APRN and placed in the Olalani Care Home Folder under the Employee's name for presence and completeness; ready for review by the consultant.	04/09/25

	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 #1 – Initial and annual TB clearances unavailable Submit a copy with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. PCG located all the necessary forms, clearances, and certificates to include initial and current TB Clearances necessary for employment to Olalani Senior Care, LLC from the Care Home Folder of Hokulaki Senior Living, LLC where SG #1 mainly work as a caregiver. Initial 2-Step TB Clearances, current and Chest X-ray clearances were copied and placed in the Olalani Senior Care Home Folder. (Copy of Initial and current TB Clearances; TB Risk and Attestation Screening Form Attached)	04/09/25

	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 #1 – Initial and annual TB clearances unavailable Submit a copy with plan of correction.	**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. Had a meeting with Staff and reviewed the 'Personnel Form' created for all employees to track down all necessary paperwork needed for the Annual Inspection, which includes Initial and current TB Clearances; TB Risk and Attestation Form. 2. PCG or designated substitute will be in-charged of checking the Employees' Initial 2-Step, Annual TB Clearances; TB Risk and Attestation Forms every 3-6 months for the review of next due date of TB Clearance exam, and to make sure that the new form has been filled out completely by the PCP/APRN and placed in the Olalani Care Home Folder under the Employee's name for presence and completeness; ready for review by the consultant.	04/09/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; **FINDINGS** SCG #1 – Valid first-aid certification unavailable Submit a copy with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. PCG located all the necessary forms, clearances, and certificates to include Adult CPR and First Aid certificate necessary for employment to Olalani Senior Care, LLC from the Care Home Folder of Hokulaki Senior Living, LLC where SG #1 mainly work as a caregiver. CPR and First Aid certificate was copied and placed in the Olalani Senior Care Home Folder. (Copy of CPR and First Aid certificate attached)	04/09/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; **FINDINGS** SCG #1 – Valid first-aid certification unavailable Submit a copy with plan of correction.	**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. Had a meeting with Staff and reviewed the 'Personnel Form' created for all employees to track down all necessary paperwork needed for the Annual Inspection, which includes CPR and First Aid certificate. 2. PCG or designated substitute will be in-charged of checking the Employees' First Aid CPR and First Aid every 3-6 months for the review of next due date of the CPR and First Aid certificate, and to make sure that the current certificate has been filled out completely and accurately by the CPR/FA Instructor and placed in the Olalani Care Home Folder under the Employee's name for presence and completeness; ready for review by the consultant.	04/09/25

	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 #1,2 – PCG training to make medications available is unavailable Submit a copy with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. RN, PCG gave an in-service to staff on the 'Importance of Training in Proper Medication Administration.' Emphasized to staff that training in proper medication administration is crucial in healthcare for several significant reasons: Patient Safety; Reduces medication errors; ensures compliance with healthcare regulations to name a few. SCGs #1, 2 were given training on Medication Preparation, Observation and Performance and the critical steps to follow when making prescribed medications available to residents. Complete training of SCG #1 due to being newly hired. (3/28/25) Retraining done for SCG #2. (Critical Steps to Follow when making prescribed medications available to residents attached)	04/09/25

	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 #1,2 – PCG training to make medications available is unavailable Submit a copy with plan of correction.	**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. Had an in-service with staff of deficiency. Staffs were reminded and retrained on the importance of following the critical steps when making prescribed medications available to residents. The critical steps list is available for review at any time and is in the locked medication cabinet. 2. Training/Retraining In-services is done every year for current employees and training new employees is usually done about a week or 2 after hire to give them the opportunity to observe the proper dispensing and proper steps in making the prescribed medications available to residents. New hire will continue to return demo a few times before on their own.	04/09/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall: Be currently certified in cardiopulmonary (CPR) resuscitation; **FINDINGS** SCG #1 – Valid CPR certification unavailable Submit a copy with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. PCG located all the necessary forms, clearances, and certificates to include Adult CPR and First Aid certificate necessary for employment to Olalani Senior Care, LLC from the Care Home Folder of Hokulaki Senior Living, LLC where SG #1 mainly work as a caregiver. CPR and First Aid certificate was copied and placed in the Olalani Senior Care Home Folder. (Copy of CPR and First Aid certificate attached)	04/09/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall: Be currently certified in cardiopulmonary (CPR) resuscitation; **FINDINGS** SCG #1 – Valid CPR certification unavailable Submit a copy with plan of correction.	**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. Had a meeting with Staff and reviewed the 'Personnel Form' created for all employees to track down all necessary paperwork needed for the Annual Inspection, which includes CPR and First Aid certificate. 2. PCG or designated substitute will be in-charged of checking the Employees' First Aid CPR and First Aid every 3-6 months for the review of next due date of the CPR and First Aid certificate, and to make sure that the current certificate has been filled out completely and accurately by the CPR/FA Instructor and placed in the Olalani Care Home Folder under the Employee's name for presence and completeness; ready for review by the consultant.	04/09/25

	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 #2 – Resident level of care assessment dated 6/24/24 observed with predetermined assessment of ARCH. Assessment does not currently reflect current resident's care status. Submit an updated level of care assessment signed and completed by physician with plan of correction. Do not pre-fill evaluation form out for physician.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. Made an appointment with Resident #2's PCP to re-evaluate resident's 'Level of Care' status. Resident was brought to PCP's clinic and discussed present status of her client. Resident was examined and re-evaluated by PCP. (Level of Care Form attached)	04/23/25

	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 #2 – Resident level of care assessment dated 6/24/24 observed with predetermined assessment of ARCH. Assessment does not currently reflect current resident's care status. Submit an updated level of care assessment signed and completed by physician with plan of correction. Do not pre-fill evaluation form out for physician.	**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. Had an inservice with staff of deficiency. Level of Care Form reviewed and discussed. 2. Informed staff that the 'Level of Care' Form' must be filled out by the Physician or APRN. The care home may provide the blank form to the PCP to be filled out by him/her and must be completed and signed by the PCP/PA/APRN. Do not prefill or X the boxes. 3. Level of Care must be done yearly and on admission/ readmission of resident to the Home.	04/23/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (l) Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets. **FINDINGS** Resident #1 and Resident #2 – Current diet order was "Regular, Minced Moist diet", however, food solids were not minced to correct size pieces and food was not served moist. No gravy/sauce was used.	**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
☒	§11-100.1-13 Nutrition. (l) Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets. **FINDINGS** Resident #1 and Resident #2 – Current diet order was "Regular, Minced Moist diet", however, food solids were not minced to correct size pieces and food was not served moist. No gravy/sauce was used.	**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. Had an in-service with PCG and Staff about the deficiency. Informed PCG and Staff that residents requiring a Regular, Minced Moist Diet often face difficulties with chewing and swallowing due to conditions like dysphagia. In such cases, incorporating gravy into the diet becomes crucial for several reasons: -Improved bolus formation and swallowing safely. -Enhanced palatability and enjoyment. -Increased caloric and nutritional intake. -Hydration to name a few. 2. The in-service concluded with the emphasis on the importance of the use of gravy in the regular, minced, moist diet. Gravy plays a vital role in making a regular, minced, moist diet safe, palatable, and nutritious for residents with swallowing difficulties. It improves the texture of food for easier swallowing, enhances flavor, and can contribute to overall nutrition and hydration. 3. It is important to ensure gravy is prepared and served at the appropriate consistency to maintain safety and optimal swallowing. 4. Consultant RD visited the facility on 4/6/25 to complete nutritional assessment and conduct staff in-service on Texture Modified Diet-Minced and Moist.	04/06/25

	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 #2 - Physician order dated 6/11/24 for 'Acetaminophen 500mg Q4hrs PRN fever/pain.' However, PRN was not available in resident's medication bin. No documentation that clarification was obtained, nor was there a discontinued order.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. A new bottle of Acetaminophen (500mg tablets) was bought to place in the resident's medication bin. The bottle was labeled with the following, "Acetaminophen (sub. for Tylenol) (500mg tablets) 1 tablet po Q4H PRN for fever or pain." as ordered by the Kaiser Permanente Medical Center ER physician. The bottle of Acetaminophen was placed in Resident #2's medication bin after proper labeling.	04/05/25

	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 #2 - Physician order dated 6/11/24 for 'Acetaminophen 500mg Q4hrs PRN fever/pain.' However, PRN was not available in resident's medication bin. No documentation that clarification was obtained, nor was there a discontinued order.	**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. Had an in-service with PCG and staff of deficiency. Informed PCG and staff to follow current OSC's Protocol for Medication that 'Doctor's order must always match the Medication Administration Record (MAR), the medication label, and the Physician's Order. Only properly labeled prescribed medications' bottles; containers; unit-dose packaging that is listed on the MAR, Physician's order must be in the medication bin. Any new prescribed medication container, after checking against the MAR, doctor's order and labeled bottle should be placed in the medication bin right away and locked. Report any discrepancies to RN. 2. PCG, Designated SCGs on AM and PM shift should check the chart of any resident coming back to the Care Home from a doctor's visit, ER visits for any new physician's order especially medication. And that includes any faxed medication orders to OSC, if any. The SCG designated for giving meds that day/shift will also check the fax machine for any new faxed medication/procedure orders. If there is any new medication order or any changes in medication order which includes but not limited to dosages, time, route, etc., the new medication or any changes in previous medication order will be transcribed onto the MAR as soon as possible; and on any changes, previous order of the same medication will be discontinued on the MAR and the new order transcribed also to the current	04/05/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. **FINDINGS** Resident #2 – Physician order dated 6/11/24 for 'Acetaminophen 500mg Q4hrs PRN fever/pain' was not observed in the resident's medication administration record (MAR) from 6/11/24-present (4/3/25) . Submit a copy of revised MAR with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. The new Acetaminophen (Tylenol) order dated 6/11/24 was transcribed on the June, 2024 MAR of the resident.	04/04/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. **FINDINGS** Resident #2 – Physician order dated 6/11/24 for 'Acetaminophen 500mg Q4hrs PRN fever/pain' was not observed in the resident's medication administration record (MAR) from 6/11/24-present (4/3/25) . Submit a copy of revised MAR with plan of correction.	**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. Had an in-service with PCG and staff of deficiency. Informed PCG and staff to follow current OSC's Protocol for Medication that 'Doctor's order must always match the Medication Administration Record (MAR), the medication label, and the Physician's Order. Only properly labeled prescribed medications' bottles; containers; unit-dose packaging that is listed on the MAR, Physician's order must be in the medication bin. Any new prescribed medication container, after checking against the MAR, doctor's order and labeled bottle should be placed in the medication bin right away and locked. Report any discrepancies to RN. 2. PCG, Designated SCGs on AM and PM shift should check the chart of any resident coming back to the Care Home from a doctor's visit for any new physician's order especially medication. And that includes any faxed medication orders to OSC, if any. The SCG designated for giving meds on day shift will also check the fax machine for any new faxed medication/procedure orders. If there is any new medication order or any changes in medication order which includes but not limited to dosages, time, route, etc., the new medication or any changes in previous medication order will be transcribed onto the MAR as soon as possible; and on any changes, previous order of the same medication will be discontinued on the MAR and the new order transcribed also to the current	04/04/25

	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 #2 – Schedule of activities not available for review Submit a copy with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. Developed a personalized 'Plan of Care and Activities' for Resident #2 (Plan of Care and Activities attached)	04/15/25

	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 #2 – Schedule of activities not available for review Submit a copy with plan of correction.	**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. Had an in-service with PCG and staff of deficiency. Reminded PCG and staff that the 'Plan of Activities' is a part of the admission paperwork of the resident, an integral part for the complete well-being of the resident. 2. Open discussion on the importance of physical activities in the elderly population which would include Resident #1. Informed staff that physical activities are important because they help residents feel a sense of belonging, purpose, and independence. They can also help reduce loneliness and cognitive decline and improve sleep and physical activity. Residents at Olalani Senior Care are always encouraged to participate in activities as they are essential for preserving and enhancing one's physical function and mobility. Most days when it is sunny out, residents are outside enjoying the plants and greeneries. They like participating in enjoyable interests and activities that increases their psychological well-being and boost physical and social well-being. 3. PCG and Staff to follow the routine and scheduled resident's personalized 'Plan of Activities' made especially for the resident daily. 4. Remind residents of favorite planned activities the day before. Recruit a resident to lead the activities. Provide and give out small prizes to residents to enhance their participation.	04/15/25

	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 #1 – Admission assessment unavailable for admission on 5/30/24 Resident #2– Admission assessment unavailable for admission on 6/24/24	**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 #1 – Admission assessment unavailable for admission on 5/30/24 Resident #2– Admission assessment unavailable for admission on 6/24/24	**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 prevent recurrence of the same deficiency in the future: 1. Had an in-service with staff of deficiency. Staffs were reminded and retrained to follow Olalani Senior Care, LLC (OSC) Protocol for Admitting new or Readmitting former returning residents to the facility, including but not limited to the completion of Admission Assessment Form as soon as the resident is admitted to the facility; Level of Care being completed and signed by PCP/PA/APRN before admission to the facility, etc. OSC's 'General and Operational and Admission Policies' was reviewed and discussed, placing emphasis on #15 on page 6. (Records and Reports) 2. OSC's 'Admission Checklist' was also reviewed and discussed. PCG and staff agreed to check that all admission paperwork and forms are completed and signed by PCP/PA/APRN on resident's admission to care home as per protocol. To prevent another omission or oversight in the future, the admitting PCG will make sure that all paperwork will be thoroughly checked for its presence and completeness. (See Attached). 3. RN will recheck all paperwork of new and readmit residents thoroughly for completeness and no missing important data after admission and during monthly review and charting.	04/15/25

	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 – Monthly progress notes unavailable from 6/2024-current (4/3/25)	**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 – Monthly progress notes unavailable from 6/2024-current (4/3/25)	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** 1. Inservice with PCG and staff done. Discussed extensively the importance and benefits of documenting a monthly progress report which include but not limited to: transparency and communication; early issue identification; decision-making support; accountability and risk management identification etc. 2. It is essential to maintain records written in the resident's medical record weekly, monthly, and as necessary for transparency to the continuity of care for the resident. All records or documentations to include but not limited to: MARs, Progress Notes, Treatments, Diet, Activity, overall reactions to medications, evaluations of plan of care, etc. and any incidences that occurred must be completed right away. Side effects and effectiveness of medications shall be included in the documentation in the overall reactions to medications. 3. All records documented and deemed done at that time should also be printed and placed in resident's medical record immediately. 4. The PCG or designated substitute will be checking the resident's medical record for the presence, accurateness, and completeness of documents every week and at the end of the month. PCG/ Designated Staff will report to RN for incomplete and missing records.	04/15/25

	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 monthly progress notes on the resident's tolerance to regular minced, moist diet with nectar thickened liquids and Ensure Nutrition Shake supplement.	**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 monthly progress notes on the resident's tolerance to regular minced, moist diet with nectar thickened liquids and Ensure Nutrition Shake supplement.	**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. Inservice with PCG and Staff done. Discussed importance of documentation of Special Diet Order outcome or resident's response to the diet monthly or more often as indicated and appropriate. Resident's nutritional documentation of a Special Diet order outcome or responses to the diet is crucial for ensuring proper nutritional care by providing a detailed record of a resident's dietary intake, allowing the identification of potential nutritional deficiencies, monitor progress for interventions and make informed decisions regarding dietary modifications, ultimately contributing to improved health outcomes especially for the elderly with chronic illnesses. 2. Reviewed: Key points about the importance of nutritional documentation include but not limited to: - Early detection of malnutrition- identifying nutritional deficiencies - Personalize nutrition plans-accurate documentation enables the creation of tailored nutrition plans based on individual needs, medical condition, and dietary restrictions. - Continuity of care-regularly assessing changes in weight, dietary intake, and clinical parameters to evaluate the effectiveness of interventions - Monitoring progress-providing evidence for quality improvement 3. Also reviewed resident's "Nutrition Assessment and Progress Note," nutritional recommendations by RD to improve nutritional health. Documentation will be done monthly in the 'Monthly Progress Report' and the tolerance of the resident to the	04/15/25

	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 the following changes in condition were monitored until resident returned to baseline: • Head injury necessitating ED visit on 7/26/24 • Right calf wound with subsequent infection requiring antibiotic treatment (3/6/25) • UTI requiring antibiotic treatment (3/13/25)	**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 the following changes in condition were monitored until resident returned to baseline: • Head injury necessitating ED visit on 7/26/24 • Right calf wound with subsequent infection requiring antibiotic treatment (3/6/25) • UTI requiring antibiotic treatment (3/13/25)	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** 1. Inservice with PCG and staff informing them that it is a must to maintain records written in the resident's medical record weekly, monthly, and as necessary for transparency to the continuity of care for the resident. All records or documentations to include but not limited to: MARs, Progress Notes, Treatments, Diet, Activity, overall reactions to medications, evaluations of plan of care, etc. and any incidences that occurred must be completed right away. Side effects and effectiveness of medications shall be included in the documentation in the overall reactions to medications. An incident report will be made when an unexpected event occurs that causes injury, property damage to equipment, safety concerns or a "near miss" situation where harm could have occurred, even if no injury or damage was present and for any adverse reactions of medications on resident that is possibly related to a drug. 2. That it is essential to monitor and report changes in a resident's health condition and it is every staff's responsibility to do so. Staff to know sign and symptoms of different common illnesses in the resident's profile and should know what to watch for and report changes in the resident's condition, document as necessary. To identify changes in the condition of a resident, the staff needs to understand what is normal (baseline) for the resident's condition. Emphasized to staff that a change in condition may mean that the resident is at risk. Action can be taken only if changes are noticed and reported, the earlier the better. Changes that are not reported can lead to serious outcomes. All records documented and deemed done at that time should also be printed and placed in resident's	04/15/25

	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 #2 – August 2024 MAR observed Depakote PRN being given daily from 8/1-/8/5 before physician ordering Depakote as a routine medication. No documented evidence of reason why PRN was being given and response to PRN medication during those times.	**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 #2 – August 2024 MAR observed Depakote PRN being given daily from 8/1-/8/5 before physician ordering Depakote as a routine medication. No documented evidence of reason why PRN was being given and response to PRN medication during those times.	**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: 1. Inservice to PCG and Staff done. Discussed the importance of documenting the reason for PRN (as needed) medication administration. Emphasized to Staff that the reason documenting why a PRN medication is given is crucial for ensuring patient safety and providing high-quality care. PRN medications are given ONLY when specific conditions or symptoms arise, and thorough documentation helps healthcare providers make informed decisions and prevent potential errors. Reasons why documenting for PRN medication is so important: A. Patient safety and effective care: -Understanding the indication: documenting the reason helps track the specific symptoms or conditions that trigger the need for the medication, allowing for evaluation of its effectiveness in addressing the targeted issue. -Preventing medication errors-This information helps avoid potential overdosing or adverse reactions by ensuring the medication is only given when truly necessary and within the prescribed parameters. -Assessing treatment efficacy: by documenting the reason and the resident's response, healthcare providers can determine if the PRN medication is working as intended or if adiustments to the	04/18/25

	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 #2 – 3/3/25 order for 'Urea (Carmol) 40% topical cream. Apply to affected area PRN dry skin' March and April 2025 MAR denotes medication being initialed as given daily, however no documented evidence of response to topical medication.	**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 #2 – 3/3/25 order for 'Urea (Carmol) 40% topical cream. Apply to affected area PRN dry skin' March and April 2025 MAR denotes medication being initialed as given daily, however no documented evidence of response to topical medication.	**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: 1. Inservice to PCG and Staff done. Discussed the importance and proper documentation for topical medication application. Emphasized that that accurate and complete documentation of topical medication administration is crucial for resident's safety, tracking progress and preventing errors. Explained to staff a breakdown of the Key Elements and Best Practices: Information to Record: - Time and Date – Document the exact time and date the medication was applied. - Medication and dosage: Record the precise medication used, including strength and the amount applied. - Application Site: Clearly indicate where on the body the medication was applied. - Resident's response: Observe and document the resident's reaction, noting any adverse effects such as redness, irritation, or allergic reactions. - Administering Staff's initials/signature: The staff who applied the medication should sign or initial the documentation. - Follow-Up: Record assessments of the medication's effectiveness and if the treatment plan requires adjustments. - Date Opened/Expiration: Record the date the product was opened on the Topical Medication Record and/or the container itself. Note the expiration date and ensure the product is not used beyond it. - Document Immediately: record the dose right after administering it to reduce errors.	04/18/25

	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 #1 – Incident report unavailable for head injury on 7/26/24 Resident #2 – Incident report unavailable for 6/11/24-6/24/24 hospitalization for cellulitis of groin	**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 #1 – Incident report unavailable for head injury on 7/26/24 Resident #2 – Incident report unavailable for 6/11/24-6/24/24 hospitalization for cellulitis of groin	**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. Inservice with PCG and staff done. Discussed the importance to maintain records written in the resident's medical record weekly, monthly, and as necessary for transparency and for the continuity of care for the resident. All records or documentations to include but not limited to: MARs, Progress Notes, Treatments, Diet, Activity, overall reactions to medications, evaluations of plan of care, etc. and any incidences that occurred must be completed right away. Side effects and effectiveness of medications shall be included in the documentation in the overall reactions to medications. An incident report will be made by PCG when an unexpected event occurs or other unusual circumstances that causes injury, property damage to equipment, safety concerns or a "near miss" situation where harm could have occurred, even if no injury or damage was present and for any adverse reactions of medications on resident that is possibly related to a drug. Place completed Incident Reports in Care Home Folder. 2. The incident report shall be made by the PCG or licensee under separate cover, and shall be made available to the Department and other authorized personnel to review. 3. The PCG or designated substitute will be checking the resident's medical record for the presence, accurateness, and completeness of documented Incident Reports every month. 4. PCG/Designated Staff will report to RN for incomplete and missing records.	04/18/25

	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 #2 – White correction tape observed on resident emergency sheet.	**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. (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 #2 – White correction tape observed on resident emergency sheet.	**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 prevent recurrence of the same deficiency in the future: 1. Had an Inservice with PCG and staff of deficiency. Proper 'Charting' and Correcting Errors without white correction tape or 'whiteout' was discussed. Retraining done to PCG and Staff, which started out why White Correction Tape or 'White Out' should not be used in nursing/medical charting because it can be interpreted as an attempt to hide information or alter the medical record, potentially undermining the integrity of the resident's care record and raising legal concerns. OSC staff should adhere to established principles for accurate and clear documentation and proper error correction protocols. - Accuracy and Factuality - Completeness and Specificity - Clarity and Legibility: Write clearly and legibly in dark (black), permanent ink to prevent misinterpretation. - Timeliness - No blank spaces-Fill in blank lines or spaced on charts with a diagonal line and signature to prevent later additions. - When correcting errors, draw a single line through the error: this allows the original entry to remain visible, demonstrating that nothing is being hidden. - Write the Correct Information: record the accurate information clearly and concisely. - Initial and Date/Time the Correction: This signifies who made the correction and when, maintaining accountability.	04/15/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-19 Resident accounts. (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative. **FINDINGS** Resident #1 – Financial statement unavailable for admission on 5/30/24 Resident #2 – Financial statement unavailable for admission on 6/24/24 Submit a copy with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. Located 'Personal Expense Statement' Forms for Residents #1 and 2, tucked in 2 separate Manila Folders for each resident together with other 'Confidential' paperwork in a locked cabinet. Placed/ Filed paperwork for each resident in their own Medical Record Charts, under 'Financial Statement'.	04/15/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-19 Resident accounts. (a) The conditions under which the primary care giver agrees to be responsible for the resident's funds or property shall be explained to the resident and the resident's family, legal guardian, surrogate or representative and documented in the resident's file. All single transfers with a value in excess of one hundred dollars shall be supported by an agreement signed by the primary care giver and the resident and the resident's family, legal guardian, surrogate or representative. **FINDINGS** Resident #1 – Financial statement unavailable for admission on 5/30/24 Resident #2 – Financial statement unavailable for admission on 6/24/24 Submit an copy with plan of correction.	**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. Had an in-service with PCG and staff of deficiency. PCG and Staffs were reminded and retrained to follow Olalani Senior Care, LLC (OSC) Protocol for Admitting new or Readmitting former returning residents to the facility, including but not limited to the completion of Admission Assessment Form and other necessary paperwork ie Financial Statement (Personal Expense Statement) the resident's family or POA needs to sign as soon as the resident is admitted to the care home to complete the admission processes. Signed Financial Statement will be filed in the resident's medical chart under the tab, 'Financial Statement." 2. OSC's 'Admission Checklist' was also reviewed and discussed. PCG and staff agreed to check that all admission paperwork and forms are completed and signed by PCP/PA/APRN on resident's admission to care home as per protocol. To prevent another omission or oversight in the future, the admitting PCG will make sure that all paperwork will be thoroughly checked for its presence and completeness. (See Attached). 3. RN will recheck all paperwork of new and readmit residents thoroughly for completeness and no missing important data after admission and during monthly review and charting.	04/15/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-20 Resident health care standards. (e) Arrangements shall be made by the primary care giver for annual dental examinations. Arrangements shall be made by the primary or substitute care giver for emergency dental examinations. **FINDINGS** Resident #1,2 – No documented evidence of annual dental exam Submit evidence of annual dental exam completed or statement of declination from resident with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. Like Immunizations and Diets, Dental Examination is visited every 3-6 months to make sure that it is not missed. Dental appointments are made for residents with their individual dentists, a minimum of every 6 months unless contraindicated by cognitive decline or mental health issues; age-related issues like choking of the residents as in the case of Residents #1 and #2. Permission is usually asked of all OSC families at the beginning of the year and mid-year to schedule resident's dental appointments. Families of both Residents #1 and #2 declined/defer dental appointments of Mother and Father respectively at this time. Documentation of reasons for deferment missed. Attached are notes from Residents' #1 and #2 of the declination of dental office visits at the present time.	05/20/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-20 Resident health care standards. (e) Arrangements shall be made by the primary care giver for annual dental examinations. Arrangements shall be made by the primary or substitute care giver for emergency dental examinations. **FINDINGS** Resident #1,2 – No documented evidence of annual dental exam Submit evidence of annual dental exam completed or statement of declination from resident with plan of correction.	**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. Had an inservice with PCG and staff of deficiency. Emphasized the importance to continue the every 6 months dental appointments for the elderly. Maintaining good oral hygiene and regular dental visits are particularly important for older adults due to increased risks of dental problems, potential links to chronic conditions, and the impact to overall health and quality of life. Dental visits help detect problems early like cavities, gum disease, and oral cancer, allowing for timely intervention and better treatment outcomes. Dentists can provide guidance on adapting oral hygiene practices for those with physical limitations or cognitive impairments. 2. Will continue to schedule dental appointments for residents at the beginning of the year and mid-year. 3. The PCG or designated substitute will be checking the resident's medical record for the presence of a scheduled dental appointments at least twice a year unless contraindicated or the presence of a note of deferment from the PCP/PA/APRN or a family member.	05/20/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(1)(A) Residents' rights and responsibilities: 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: Be fully informed orally or in writing, prior to or at the time of admission, of these rights and of all rules governing resident conduct. There shall be documentation signed by the resident that this procedure has been carried out; **FINDINGS** Resident #1 – Signed copy resident was informed of their rights and responsibilities unavailable for admission on 5/30/24 Submit a copy with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. The daughter of Resident #1, was handed another copy of OSC's 'General and Operational and Admission Policies' which includes the Resident's Bill of Rights, ARCH Policies, rules and general information and guidelines of the Olalani Senior Care, LLC facility where Resident #1 is being cared for during her visit at Olalani Care Home.	04/15/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(1)(A) Residents' rights and responsibilities: 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: Be fully informed orally or in writing, prior to or at the time of admission, of these rights and of all rules governing resident conduct. There shall be documentation signed by the resident that this procedure has been carried out; **FINDINGS** Resident #1 – Signed copy resident was informed of their rights and responsibilities unavailable for admission on 5/30/24 Submit a copy with plan of correction.	**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 prevent recurrence of the same deficiency in the future: 1. Had an Inservice with PCG and staff of deficiency. Staffs were reminded and retrained to follow Olalani Senior Care, LLC (OSC) Protocol for Admitting new or Readmitting former returning residents to the facility, including but not limited to the completion of Admission Assessment Form as soon as the resident is admitted to the facility. OSC's 'General and Operational and Admission Policies' was reviewed and discussed, placing emphasis on the family member or POA (Power of Attorney) signing the 'Statement of Acknowledgement' Form after the POA's reading, understanding, and accepting the ARCH's policies, rules, guidelines and general information and all questions regarding admission have been thoroughly answered. 2. OSC's 'Admission Checklist' was also reviewed and discussed. PCG and staff agreed to using Admission Checklist so not to miss any admission paperwork and forms, to include signing of the Statement of Acknowledgement by the Resident's POA, which is a part of OSC's General Operational and Admission Policies to be completed on admission to the care home as per protocol. To prevent another omission or oversight in the future, the admitting PCG will make sure that all paperwork will be thoroughly checked for its presence and completeness. (See Attached). 3. RN will recheck all paperwork of new and readmit residents	04/15/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(1)(C) Residents' rights and responsibilities: 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: 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; **FINDINGS** Resident #1 – No documented evidence resident was informed verbally and in writing of services available and related charges at the time of admission on 5/30/24 Resident #2 – No documented evidence resident was informed verbally and in writing of services available and related charges at the time of admission on 6/24/24 Submit a copy with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. Located 'Acknowledgement of Receipt of Admissions Policies and Contract' Forms for Resident #1 and 2, tucked in 2 separate Manila Folders for each resident together with other 'Confidential' paperwork in a locked cabinet in the care home office. Attached signed forms for Residents #1 and #2 for review.	04/15/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-21 Residents' and primary care givers' rights and responsibilities. (a)(1)(C) Residents' rights and responsibilities: 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: 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; **FINDINGS** Resident #1 – No documented evidence resident was informed verbally and in writing of services available and related charges at the time of admission on 5/30/24 Resident #2 – No documented evidence resident was informed verbally and in writing of services available and related charges at the time of admission on 6/24/24 Submit a copy with plan of correction.	**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. Had an Inservice with PCG and staff of deficiency. PCG and Staffs were re-informed and retrained to follow Olalani Senior Care, LLC (OSC) Protocol for Admitting new or Readmitting former returning residents to the facility, including but not limited to the completion of Admission Assessment Form. Other necessary paperwork to be signed by the resident's family or POA is OSC's 'General and Operational and Admission Policies' which includes the services rendered to the resident with specific charges to the services. 'Admission Checklist' was also reviewed and discussed. PCG and staffs to check that all admission paperwork and forms are completed and signed by PCP/PA/APRN on resident's admission to care home as per protocol. To prevent another omission or oversight in the future, the admitting RN or PCG will make sure that all paperwork will be thoroughly checked for its presence and completeness to include signed 'Acknowledgement of Receipt of monthly charges and rates which will remain under lock and key for confidentiality purposes. (See Attached). 2. RN will recheck all paperwork of new and readmit residents thoroughly for completeness and no missing important form after admission and during monthly review and charting.	04/15/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-23 Physical environment. (g)(3)(I) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: 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: **FINDINGS** Resident #2 – Resident observed to require 1:1 and 2:1 assistance with ambulation and use of walker, and frequent redirection while staff pulling a wheelchair behind them. Self preservation statement signed by physician on 6/24/24 had predetermined/typed out "(stand-by assist)" next to a predetermined/typed out 'is ambulatory' check box. Statement 'is capable of following direction' was also predetermined/typed out. Submit an updated self-preservation statement completed by a physician with plan of correction. Do not pre-fill evaluation or make edits to the evaluation form.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. Made an appointment with Resident #2's PCP to re-evaluate resident's 'Self Preservation's Form status.' Resident was brought to PCP's clinic and discussed present status of her patient. Resident was examined and re-evaluated by PCP. ('Self-Preservation Form and PCP's doctor's notes attached)	04/23/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-23 Physical environment. (g)(3)(I) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions: 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: **FINDINGS** Resident #2 – Resident observed to require 1:1 and 2:1 assistance with ambulation and use of walker, and frequent redirection while staff pulling a wheelchair behind them. Self preservation statement signed by physician on 6/24/24 had predetermined/typed out "(stand-by assist)" next to a predetermined/typed out 'is ambulatory' check box. Statement 'is capable of following direction' was also predetermined/typed out. Submit an updated self-preservation statement completed by a physician with plan of correction. Do not pre-fill evaluation or make edits to the evaluation form.	**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. Had an in-service with staff of deficiency. Self-Preservation Form reviewed and discussed. PCG and staff familiarized themselves with Chapter 11-100.1 Certification of a resident in a Type I ARCH by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions. (11-100.1-23 (g)(3)(1). The above was discussed between PCG and staff for self-preservation in case of fire and other emergencies, ie. natural disasters and hazardous material incidents. 2. Informed staff that the 'Self-Preservation Form' must be filled out by the Physician or APRN. The care home may provide the blank form to the PCP to be filled out by him/her and must be completed and signed by the PCP/PA/APRN. Do not prefill the boxes.	04/23/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-54 General operational policies. (1) In addition to the requirements in section 11-100.1-7, the Type II ARCH shall have general operational policies on the following topics: Nursing services, delegation and staffing pattern/ratio; **FINDINGS** SCG #1 – Employee observed working at two different type II E-ARCHs (Olalani Senior Care, LLC and Hokulaki Senior Living, L.L.C.) simultaneously at the start of annual inspection.	**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
☒	§11-100.1-54 General operational policies. (1) In addition to the requirements in section 11-100.1-7, the Type II ARCH shall have general operational policies on the following topics: Nursing services, delegation and staffing pattern/ratio; **FINDINGS** SCG #1 – Employee observed working at two different type II E-ARCHs (Olalani Senior Care, LLC and Hokulaki Senior Living, L.L.C.) simultaneously at the start of annual inspection.	**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. Inservice done with PCG and Staffs. It was discussed extensibly that NO Employee will be working at 2 different E-ARCHs (Olalani Senior Care and Hokulaki Senior Living, simultaneously on the same shift. Both E-ARCHs will continue to maintain a 2-caregiver staffing model per shift to improve resident's safety and quality of care; for timely and effective care delivery, especially for residents with higher acuity levels and allows for quicker responses to resident needs and emergencies, to name a few crucial benefits. 2. RN and/or PCG will check the work schedule the day before to make sure no employee is working in both facilities on the same shift. 3. PCG or Staff will report work schedule discrepancies to RN.	04/09/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-55 Nutrition and food sanitation. (1) In addition to the requirements in section 11-100.1-13 the following shall apply to all Type II ARCHs: A registered dietitian shall be utilized to assist in the planning of menus, and provide nutritional assessments for those residents identified to be at nutritional risk or on special diets. All consultations shall be documented; **FINDINGS** Resident #1 – No documented evidence that the facility utilized the Consultant Registered Dietitian to provide nutritional assessment for resident with identified nutrition risks – Regular, minced, moist diet with nectar thickened liquids and Ensure supplement. Resident #2 – No documented evidence that the facility utilized the Consultant Registered Dietitian to provide nutritional assessment for resident with identified nutrition risks – Regular, minced, moist with nectar thickened liquids and Boost Plus supplement. Submit a copy of nutritional assessment completed by registered dietitian with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency was corrected. The Registered Dietitian (RD) was called by PCG to inform her of new deficiency citation. Made an appointment with RD to visit the Olalani Senior E-ARCH Care Home to provide nutritional assessment for Resident #1 and Resident #2, identified as nutritional risks due to difficulty swallowing, both needing a modified texture diet: Regular, Minced, Moist with nectar-thickened liquids and Ensure and Boost Plus Supplements respectively. The RD Consultant visited facility on 4/6/25 to complete nutritional assessments for both Residents' #1, #2, and conducted Staff Inservice on Texture Modified Diet: Minced and Moist. (Nutrition Assessment and Progress Note for 2 residents attached) (Info on Inservice also attached)	04/06/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-55 Nutrition and food sanitation. (1) In addition to the requirements in section 11-100.1-13 the following shall apply to all Type II ARCHs: A registered dietitian shall be utilized to assist in the planning of menus, and provide nutritional assessments for those residents identified to be at nutritional risk or on special diets. All consultations shall be documented; **FINDINGS** Resident #1 – No documented evidence that the facility utilized the Consultant Registered Dietitian to provide nutritional assessment for resident with identified nutrition risks – Regular, minced, moist diet with nectar thickened liquids and Ensure supplement. Resident #2 – No documented evidence that the facility utilized the Consultant Registered Dietitian to provide nutritional assessment for resident with identified nutrition risks – Regular, minced, moist with nectar thickened liquids and Boost Plus supplement. Submit a copy of nutritional assessment completed by registered dietitian with plan of correction.	**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. Inservice done with PCG and Staffs. Informed and discussed with PCG and Staffs the importance of nutritional assessments as they are crucial for identifying and addressing potential health problems related to diet and overall well-being. They help determine if a resident is getting enough or too much of essential nutrients, and whether they are at risk for diet-related diseases. By assessing nutritional status, healthcare professionals ie. RD can develop personalized interventions to improve health outcomes and prevent future complications. 2. Continue to fill out 'Nutrition Referral and Screening' Form on new resident's admission to the facility and to be faxed to RD; followed by a phone call to inform RD of new admission. May make an appointment with RD at this time for the next visit with new and present residents. 3. PCG, or assigned substitute caregiver will check the residents' Medical Record for the presence of the 'Nutrition Assessment and Progress Notes' and other dietary forms under the tab "Nutrition Record" every 3 months and randomly to also check for accurateness, and completeness of the forms.	04/06/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-83 Personnel and staffing requirements. (5) In addition to the requirements in subchapter 2 and 3: Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents. **FINDINGS** SCG #1 – Twelve (12) hours of annual continuing education unavailable Submit evidence of twelve hours of completed continuing education with plan of correction.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** The deficiency cannot be corrected at this time. SCG #1 was hired into Hokulaki Senior Living, LLC on March 31, 2025. Annual Inspection was conducted on April 3, 2025.	04/19/25

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-83 Personnel and staffing requirements. (5) In addition to the requirements in subchapter 2 and 3: Primary and substitute care givers shall have documented evidence of successful completion of twelve hours of continuing education courses per year on subjects pertinent to the management of an expanded ARCH and care of expanded ARCH residents. **FINDINGS** SCG #1 – Twelve (12) hours of annual continuing education unavailable Submit evidence of twelve hours of completed continuing education with plan of correction.	**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. SCG #1 will attend future In-services to accumulate 12 continuing education hours for the year 2025-2026, to fulfill the annual requirement for continuing education. 2. To develop good education and learning, SCG #1 will attend essential in-services beyond the mandated topics. While Standard Precautions, confidentiality, nutrition, pain management and dementia care are necessary, SCG #1 will also take some additional and crucial in-services such as Understanding Resident Preferences; Advanced Dementia Care; Assertiveness Training; Care Planning and Individualized Care; Wound Care and Skin Integrity; Infection Control Best Practices, etc. 3. Informed SCG #1 and other staffs that by engaging in these targeted in-services, they can enhance their skills, provide more comprehensive and personalized care, and contribute to a higher quality of life for the care home residents. 4. PCG and designated SCG will check the 'Personnel Form' every 3-6 months for the presence of continuing education certificates in the individual employee folder.	04/19/25

Licensee's/Administrator's Signature: Myriam Tabaniag

Print Name: MYRIAM TABANIAG

Date: 07/21/25