

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: De Rego Care Home	CHAPTER 100.1
Address: 224 Lanialii Street, Wahiawa, Hawaii 96786	Inspection Date: December 5, 2026 Annual

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

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

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

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-3 <u>Licensing</u>, (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; <u>FINDINGS</u> Substitute Care Giver (SCG) #1, Household Member (HHM) – No current documented evidence that aforementioned care giver has no prior history of felony or abuse convictions in a court of law, on file.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-3 <u>Licensing.</u> (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; <u>FINDINGS</u> SCG #1, HHM – No current documented evidence that aforementioned care giver has no prior history of felony or abuse convictions in a court of law, on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-8 <u>Primary care giver qualifications.</u> (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall: Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current; <u>FINDINGS</u> Primary Care Giver (PCG) – No documented evidence of six (6) continuing education hours completed within a twelve (12) month period. Four (4) hours completed and on file.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-8 <u>Primary care giver qualifications.</u> (a)(10) The licensee of a Type I ARCH acting as a primary care giver or the individual that the licensee has designated as the primary care giver shall: Attend and successfully complete a minimum of six hours of training sessions per year which shall include but not be limited to any combination of the following areas: personal care, infection control, pharmacology, medical and behavioral management of residents, diseases and chronic illnesses, community services and resources. All inservice training and other educational experiences shall be documented and kept current; <u>FINDINGS</u> PCG – No documented evidence of six (6) continuing education hours completed within a twelve (12) month period. Four (4) hours completed and on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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. <u>FINDINGS</u> PCG, SCG #1, HHM – No documented evidence of a current physical examination clearance by a physician or advanced practice registered nurse (APRN) on file.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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. <u>FINDINGS</u> PCG, SCG #1, HHM – No documented evidence of a current physical examination clearance by a physician or APRN on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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. <u>FINDINGS</u> PCG, HHM #1 – No documented evidence of a current tuberculosis clearance by a physician or APRN on file.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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☒	§11-100.1-10 <u>Admission policies.</u> (g) An inventory of all personal items brought into the Type I ARCH by the resident shall be maintained. <u>FINDINGS</u> Resident #5 – No documented evidence of an inventory of all personal items brought into the adult residential care home (ARCH) on admission.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 <u>Nutrition.</u> (d) Current menus shall be posted in the kitchen and in a conspicuous place in the dining area for the residents and department to review. <u>FINDINGS</u> Resident #5 – Physician ordered cardiac diet. No cardiac diet menu created for resident.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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. <u>FINDINGS</u> Resident #1, Resident #2 – No documented evidence of a current annual diet order by a physician or APRN on file.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 <u>Food sanitation.</u> (a) All food shall be procured, stored, prepared and served under sanitary conditions. <u>FINDINGS</u> Observed scattered food items on shelving and bottom of facility refrigerator.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 <u>Food sanitation.</u> (a) All food shall be procured, stored, prepared and served under sanitary conditions. <u>FINDINGS</u> Observed case of bottled water and a box of canned goods stored on facility floor.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 <u>Food sanitation.</u> (b) All foods shall be stored in covered containers. <u>FINDINGS</u> Observed four (4) paper plates of food in facility refrigerator, uncovered.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§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. <u>FINDINGS</u> Resident #1 – Physician ordered “Acetaminophen 500mg tab, take 2 tablets by mouth every 8 hours as needed for pain or fever.” Acetaminophen medication bottle in medication bin without medication label.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. <u>FINDINGS</u> Resident #1 – Observed “Mirtazapine 15mg,” “Vitamin B-1100mg tablet,” and “Rizatriptan 5mg” in resident’s medication bin. No physician or APRN orders on file for aforementioned medications.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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☒	§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. <u>FINDINGS</u> Resident #1 – Observed “Mirtazapine 15mg,” “Vitamin B-1100mg tablet,” and “Rizatriptan 5mg” in resident’s medication bin. Aforementioned medications not documented on January 2025 – November 2025 medication administration records (MAR).	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

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☒	§11-100.1-15 <u>Medications.</u> (g) All medication orders shall be reevaluated and signed by the physician or APRN every four months or as ordered by the physician or APRN, not to exceed one year. <u>FINDINGS</u> Resident #1 – No documented evidence that all medication orders were reevaluated and signed by a physician or APRN at least every four (4) months on file.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

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☒	§11-100.1-15 <u>Medications.</u> (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications. <u>FINDINGS</u> Resident #1 – Observed a loose pink tablet in medication bin.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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☒	§11-100.1-15 <u>Medications.</u> (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications. <u>FINDINGS</u> Resident #2 – Observed resident’s “Insulin Solostar” unsecured in facility refrigerator.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

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☒	§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #1 – No documented evidence that resident medications were either administered to the resident, refused by the resident, or held by the facility from 11/26/2025 – 12/4/2025. Entries for those dates on the November 2025 MAR were blank. No December 2025 MAR on file.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

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☒	§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #2 – No documented evidence that resident medications were either administered to the resident, refused by the resident, or held by the facility from 11/26/2025 – 12/4/2025. Entries for those dates on the November 2025 MAR were blank. No December 2025 MAR on file.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #2 – No documented evidence that resident medications were either administered to the resident, refused by the resident, or held by the facility from 11/26/2025 – 12/4/2025. Entries for those dates on the November 2025 MAR were blank. No December 2025 MAR on file. 2025 MAR were blank. No December 2025 MAR on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #3 – No documented evidence that resident medications were either administered to the resident, refused by the resident, or held by the facility from 11/24/2025 – 12/4/2025. Entries for those dates on the November 2025 MAR were blank. No December 2025 MAR on file.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #3 – No documented evidence that resident medications were either administered to the resident, refused by the resident, or held by the facility from 11/24/2025 – 12/4/2025. Entries for those dates on the November 2025 MAR were blank. No December 2025 MAR on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #4 – No documented evidence that resident medications were either administered to the resident, refused by the resident, or held by the facility from 7/14/2025 – 12/4/2025. No MAR on file.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #4 – No documented evidence that resident medications were either administered to the resident, refused by the resident, or held by the facility from 7/14/2025 – 12/4/2025. No MAR on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #5 – No documented evidence that resident medications were either administered to the resident, refused by the resident, or held by the facility from 12/1/2025 – 12/4/2025. No December 2025 MAR on file.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #5 – No documented evidence that resident medications were either administered to the resident, refused by the resident, or held by the facility from 12/1/2025 – 12/4/2025. No December 2025 MAR on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #1 – Observed “Mirtazapine 15mg,” “Vitamin B-1100mg tablet,” and “Rizatriptan 5mg” in resident’s medication bin. No documented evidence that resident medications were either administered to the resident, refused by the resident, or held by the facility from 1/1/2025 – 12/4/2025. Medications not documented on MARs but was given per verbal confirmation from PCG.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #1 – Observed “Mirtazapine 15mg,” “Vitamin B-1100mg tablet,” and “Rizatriptan 5mg” in resident’s medication bin. No documented evidence that resident medications were either administered to the resident, refused by the resident, or held by the facility from 1/1/2025 – 12/4/2025. Medications not documented on MARs but was given per verbal confirmation from PCG.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN’T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #1 - Observed “Rizatriptan 5mg” in resident’s medication bin. Nine (9) tablets were dispensed on 9/22/2025 by pharmacy. Only one (1) tablet remaining in bottle. No documentation when medication was given and if medication was effective or ineffective, on file.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 <u>Medications.</u> (m) All medications and supplements, such as vitamins, minerals, and formulas, when taken by the resident, shall be recorded on the resident's medication record, with date, time, name of drug, and dosage initialed by the care giver. <u>FINDINGS</u> Resident #1 - Observed “Rizatriptan 5mg” in resident’s medication bin. Nine (9) tablets were dispensed on 9/22/2025 by pharmacy. Only one (1) tablet remaining in bottle. No documentation when medication was given and if medication was effective or ineffective, on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN’T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (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; <u>FINDINGS</u> Resident #3, Resident #4, Resident #5 – Aforementioned residents all admitted in 2025. No documented evidence of an admission assessment done by PCG on admission.	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 <u>Records and reports.</u> (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; <u>FINDINGS</u> Resident #3, Resident #4, Resident #5 – Aforementioned residents all admitted in 2025. No documented evidence of an admission assessment done by PCG on admission.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (a)(7) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Height and weight measurements taken; <u>FINDINGS</u> Resident #3 – Resident admitted 12/28/2024. No documented evidence of an admission weight on file.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (a)(7) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Height and weight measurements taken; <u>FINDINGS</u> Resident #3 – Resident admitted 12/28/2024. No documented evidence of an admission weight on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (a)(7) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Height and weight measurements taken; <u>FINDINGS</u> Resident #4, Resident #5 – No documented evidence of a height and weight on admission.	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 <u>Records and reports.</u> (a)(7) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: Height and weight measurements taken; <u>FINDINGS</u> Resident #4, Resident #5 – No documented evidence of a height and weight on admission.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (a)(8) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: A current inventory of money and valuables. <u>FINDINGS</u> Resident #1, Resident #2 – No documented evidence of a current inventory of belongings on file.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (a)(8) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: A current inventory of money and valuables. <u>FINDINGS</u> Resident #1, Resident #2 – No documented evidence of a current inventory of belongings on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; <u>FINDINGS</u> Resident #2 – No documented evidence of a current physical examination clearance by a physician or APRN on file.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; <u>FINDINGS</u> Resident #2 – No documented evidence of a current physical examination clearance by a physician or APRN on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; <u>FINDINGS</u> Resident #2, Resident #4 – No documented evidence of a current tuberculosis clearance by a physician or APRN on file.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; <u>FINDINGS</u> Resident #2, Resident #4 – No documented evidence of a current tuberculosis clearance by a physician or APRN on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; <u>FINDINGS</u> Resident #1, Resident #2 – No documented evidence of a current level of care evaluation by a physician or APRN on file.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; <u>FINDINGS</u> Resident #1, Resident #2 – No documented evidence of a current level of care evaluation by a physician or APRN on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; <u>FINDINGS</u> Resident #1, Resident #2, Resident #3 – No documented evidence of progress notes documented for the past twelve (12) months on file.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; <u>FINDINGS</u> Resident #1, Resident #2, Resident #3 – No documented evidence of progress notes documented for the past twelve (12) months on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; <u>FINDINGS</u> Resident #1, Resident #2, Resident #3 – No documented evidence of resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury and behavior patterns for the past twelve (12) months on file.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; <u>FINDINGS</u> Resident #1, Resident #2, Resident #3 – No documented evidence of resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury and behavior patterns for the past twelve (12) months on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; <u>FINDINGS</u> Resident #4 - No documented evidence of progress notes documented for the past five (5) months since admission, on file.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; <u>FINDINGS</u> Resident #4 - No documented evidence of progress notes documented for the past five (5) months since admission, on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; <u>FINDINGS</u> Resident #4 – No documented evidence of resident’s response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury and behavior patterns for the past five (5) months on file.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; <u>FINDINGS</u> Resident #4 – No documented evidence of resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury and behavior patterns for the past five (5) months on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(7) During residence, records shall include: Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency; <u>FINDINGS</u> Resident #4 – Resident admitted 7/14/2025. No documented evidence of monthly weights from 7/2025 – 11/2025, on file.	PART 1 Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (b)(7) During residence, records shall include: Recording of resident's weight at least once a month, and more often when requested by a physician, APRN or responsible agency; <u>FINDINGS</u> Resident #4 – Resident admitted 7/14/2025. No documented evidence of monthly weights from 7/2025 – 11/2025, on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (f)(3) General rules regarding records: An area shall be provided for safe and secure storage of resident's records which must be retained in the ARCH for periods prescribed by state law; <u>FINDINGS</u> Resident #5 – Per PCG, previous admissions' records shredded. Documents not retained for periods required by law.	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 <u>Records and reports.</u> (f)(3) General rules regarding records: An area shall be provided for safe and secure storage of resident's records which must be retained in the ARCH for periods prescribed by state law; <u>FINDINGS</u> Resident #5 – Per PCG, previous admissions’ records shredded. Documents not retained for periods required by law.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; <u>FINDINGS</u> Resident #5 – Per PCG, resident was admitted for several months in early part of 2025. No documented evidence of resident’s admission and discharge on facility’s permanent resident register.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; <u>FINDINGS</u> Resident #5 – Per PCG, resident was admitted for several months in early part of 2025. No documented evidence of resident’s admission and discharge on facility’s permanent resident register.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN’T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; <u>FINDINGS</u> Resident #5 – Resident admitted to facility on 12/1/2025. Admission not documented on facility’s permanent resident register.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 <u>Records and reports.</u> (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; <u>FINDINGS</u> Resident #5 – Resident admitted to facility on 12/1/2025. Admission not documented on facility’s permanent resident register.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN’T HAPPEN AGAIN?	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-23 <u>Physical environment.</u> (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: <u>FINDINGS</u> Resident #1, Resident #2 – No documented evidence of a current self-preservation evaluation by a physician or APRN on file.	PART 1 <u>DID YOU CORRECT THE DEFICIENCY?</u> USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-23 <u>Physical environment.</u> (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: <u>FINDINGS</u> Resident #1, Resident #2 – No documented evidence of a current self-preservation evaluation by a physician or APRN on file.	PART 2 <u>FUTURE PLAN</u> USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?	

Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____