Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Kupuna Loving Care Home	**CHAPTER 100.1**
Address: 2024 Uhu Street, Honolulu, Hawaii 96819	**Inspection Date: April 6, 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
☒	§11-100.1-9 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** Primary Caregiver (PCG), Substitute Caregiver (SCG) #1-3 – 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** Correction completed immediately All Identified staff where instructed to obtain updated physical examination Appointment were schedule promptly to ensure compliance Any staff with out physical clearance will not be able to work until proper documentation until proper documentation is completed and verified Documentation will be placed in staff personnel file upon completion	04/20/26

	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** Primary Caregiver (PCG), Substitute Caregiver (SCG) #1-3 – 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?** Future Plan Monitoring Staff clearing tracking log will be implemented including physical exams, TB clearance and other required documents Physical Exam will be required prior to hire and maintain as current per regulatory requirements The PCG will conduct quarterly audits of all personnel files to ensure compliance A reminder system (calendar/log) will be used to track expiration dates and renewals in advance Staff will be educated on maintaining up to date health requirements as a condition of employment Quality Assurance Compliance will be reviewed during monthly internal audits Any missing or expired documentation will be corrected upon discovery Records will be ready available to review during inspection	04/20/26

	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 #3 – 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** Correction The Primary CareGiver (PCG) provided immediate re training to SCG #3 on proper medication procedure including Accessing medications from the locked med cabinet Proper preparation and availability of medications at scheduled times Medication safety and storage protocols Accurate documentation on the Med Administration Record (MAR) SCG#3 demonstrated understanding through return demonstration A training documentation form was completed signed and file in the personal record	04/20/26

	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 #3 – 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?** Future Plan All caregivers will receive documented PCG training on medication handling prior to assignment A standardized Medication Training Checklist will be used for all staff Caregivers must complete competency evaluation 9return demonstration) before handling medication independently The PCG will conduct quarterly reviews and competency checks for all caregivers A training log will be maintained to ensure all required education is current and available for inspection to ensure completeness and accuracy Monthly audits of personnel files will ensure all required training documentation is complete Any missing documentation will be addressed immediately with retraining and documentation completion Ongoing supervision will ensure compliance with medication procedure and safety standards	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (b) Menus shall be written at least one week in advance, revised periodically, dated, and followed. If cycle menus are used, there shall be a minimum of four weekly menus. **FINDINGS** Regular diet menu does not include serving sizes (by volume) on all food/beverage items Submit a revised menu with plan of correction	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Correction (Completed Immediately) the regular diet menu was reviewed and revised immediately All food and beverage items now include appropriate serving sizes by volume (e.g. cups ounces tablespoons) The updated menu was posted in the kitchen and made available for staff reference	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (b) Menus shall be written at least one week in advance, revised periodically, dated, and followed. If cycle menus are used, there shall be a minimum of four weekly menus. **FINDINGS** Regular diet menu does not include serving sizes (by volume) on all food/beverage items Submit a revised menu 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?** All menus(regular and special diets) will include clearly defined serving sizes by volume Menu will be reviewed weekly by the Primary CareGiver (PCG) to ensure completeness and accuracy Any updates or changes to meals will be immediately revised on the posted menu Caregivers will be trained to follow standardized portion size to ensure consistency and compliance Monthly audits will be conducted to ensure menus remain compliant with regulatory requirements Any discrepancies identified will be corrected immediately Documentation of menu reviews will be maintained for inspection readiness	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (b) Menus shall be written at least one week in advance, revised periodically, dated, and followed. If cycle menus are used, there shall be a minimum of four weekly menus. **FINDINGS** Resident # 2 – Special diet menu for diet order dated 1/3/26, "Diabetic 2,000kcal diet, chopped", unavailable Submit a copy of special diet menu with plan of correction	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Correction (completed Immediately) A special diet menu specific to Resident #2 was immediately developed based on the ordered Diabetic 2,000Kcal chopped diet chopped diet The menu includes appropriate food selection calories considerations and texture modification (chopped) The updated special diet menu was posted in the kitchen and made accessible to all caregivers Caregivers were instructed to follow the updated diet order strictly	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (b) Menus shall be written at least one week in advance, revised periodically, dated, and followed. If cycle menus are used, there shall be a minimum of four weekly menus. **FINDINGS** Resident # 2 – Special diet menu for diet order dated 1/3/26, "Diabetic 2,000kcal diet, chopped", unavailable Submit a copy of special diet menu 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?** Future Plan All residents with special diet orders will have a corresponding individualized menu developed and maintained Diet orders from Physicians/APRN will be reviewed immediately upon receipt and menus will be updated accordingly A diet tracking log will be implemented to ensure all ordered diets are reflected in posted menus The Primary Caregiver (PCG)) will conduct weekly reviews of all diet menus to ensure accuracy and compliance Staff will be trained on diet order compliance including diabetic texture-modified diets Monthly audits will verify that all residents with special diets have current posted and compliant menus Any discrepancies will be corrected immediately upon identification Documentation of menu updates and reviews will be maintained for inspection	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (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. **FINDINGS** Resident #2 – Special diet menu not posted in kitchen/dining area	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Correction The special diet menu for Resident#2 was immediately posted in the kitchen and dinning area The menu reflects the resident's ordered diet (Diabetic 2,000 Kcal chopped diet) All caregivers were informed and instructed to follow the post diet menu	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (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. **FINDINGS** Resident #2 – Special diet menu not posted in kitchen/dining area	**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 All residents with special diet orders will have their individualized diet menus posted in the kitchen and dinning area at all times Any new or updated diet orders will be implemented and posted immediately upon receipt The Primary Caregiver (PCG) will conduct weekly checks to ensure all required menus are properly posted and current Staff will be re-educated on the importance of visible and accessible diet menus for compliance and resident safety Monthly audits will be conducted to verify that all special diet menus are posted Any missing or outdated postings will be corrected immediately Documentation of audits will be maintained for inspection readiness	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 Food sanitation. (a) All food shall be procured, stored, prepared and served under sanitary conditions. **FINDINGS** Box of juice cans stored directly on kitchen floor	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Correction The box of juice cans was immediately removed from the floor and placed on a clean elevated surface/shelf The storage area was checked to ensure all beverages were properly stored	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 Food sanitation. (a) All food shall be procured, stored, prepared and served under sanitary conditions. **FINDINGS** Box of juice cans stored directly on kitchen floor	**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 All beverage items will be stored t least 6 inches above the floor on shelves or appropriate storage unit The Primary Caregiver (PCG) will conduct daily kitchen inspections to ensure proper food storage practices are followed All staff will be re educated on safe food storage requirements including maintaining cleanliness and preventing contamination Storage areas will be kept organized and free from improper placement of items Weekly audits will be conducted to ensure compliance with food safety and storage Any deficiencies identified will be corrected immediately Documentation of inspection will be maintained for review during surveys	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 Food sanitation. (d) Potentially hazardous food shall meet proper temperature requirements during storage, preparation, display, service, and transportation. **FINDINGS** PCG reports cooking food to 38°F, below minimum safe temperature of 165°F	**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
☒	§11-100.1-14 Food sanitation. (d) Potentially hazardous food shall meet proper temperature requirements during storage, preparation, display, service, and transportation. **FINDINGS** PCG reports cooking food to 38°F, below minimum safe temperature of 165°F	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Future All staff will received formal training on food safety and proper cooking temperature including safe handling cooking and reheating guidelines A food temperature reference chart will be posted in the kitchen for easy reference The PCG will conduct routine supervision and spot checks to ensure compliance with proper cooking practices A food safety log (temperature monitoring) will be implemented when applicable Weekly kitchen audits will include verification of proper food handling and cooking temperatures Any identified issues will be corrected immediately with re-education and monitoring Documentation of training and audits will be maintained for inspection readiness	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 Food sanitation. (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies. **FINDINGS** Bathroom #1 – Toilet bowl liquid cleaner stored unsecured in bathroom Bathroom #2 – Bottle of Lysol sanitizing spray stored unsecured on bathroom drawer stand and toxic cleaning agents stored unsecured in bathroom sink cabinet	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Correction (Completed Immediately) All identified cleaning agents and toxic cleaning substances were immediately removed from the unsecured areas]Items were placed in a locked cabinet/secured storage area inaccessible to residents. Bathroom were re checked to ensure no hazardous materials remained accessible	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-14 Food sanitation. (f) Toxic chemicals and cleaning agents, such as insecticides, fertilizers, bleaches and all other poisons, shall be properly labeled and securely stored apart from any food supplies. **FINDINGS** Bathroom #1 – Toilet bowl liquid cleaner stored unsecured in bathroom Bathroom #2 – Bottle of Lysol sanitizing spray stored unsecured on bathroom drawer stand and toxic cleaning agents stored unsecured in bathroom sink cabinet	**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/Monitoring All cleaning agents, disinfectants and toxic substances will be stored in locked cabinets or secured areas at all times A designated storage area for hazardous materials will be maintained. The primary caregiver (PCG) will conduct daily environmental safety checks of all bathrooms and common areas All staff will be re educated on safe storage of hazardous materials and resident safety protocols Cabinets containing toxic agent will be clearly labeled Locked- Cleaning Supplies	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. **FINDINGS** Bathroom #1 – Unlabeled bottle of latanoprost stored on bathroom sink	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Correction (Completed Immediately) The unlabeled latanoprost bottle was immediately removed from the bathroom sink The medication was properly identified and verified with the corresponding resident Relabeled appropriately with resident identification or The medication was discard per protocol if unable to verify The medication was placed in the designated secured medication storage	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (a) All medicines prescribed by physicians and dispensed by pharmacists shall be deemed properly labeled so long as no changes to the label have been made by the licensee, primary care giver or any ARCH/Expanded ARCH staff, and pills/medications are not removed from the original labeled container, other than for administration of medications. The storage shall be in a staff controlled work cabinet-counter apart from either resident's bathrooms or bedrooms. **FINDINGS** Bathroom #1 – Unlabeled bottle of latanoprost stored on bathroom sink	**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 All medication will be kept in their original labeled containers or appropriately labeled if required Medications will be stored only in secured designated medication area not in bathrooms or unsecured locations the Primary Caregiver (PCG) will conduct daily medication area checks to ensure compliance All staff will be re-educated on proper medication labeling storage and safety protocols A medication storage policy review will be reinforced with all caregivers Weekly audits will ensure no unlabeled or improperly stored medication are present Any discrepancies will be corrected immediately with restraining and documentation Documentation of audits and corrective actions will maintained for inspection readiness	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container. **FINDINGS** Bathroom #1 – Unlabeled bottle of latanoprost stored unsecured on bathroom sink	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Correction The medication was immediately removed from the bathroom sink The medication was verified against the resident's prescription The bottle was either Returned to the original labeled container or Discarded per protocol if identification could not be confirmed The medication wa placed in the designated locked staff-controlled medication cabinet under proper storage condition	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (b) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security. Medications that require storage in a refrigerator shall be properly labeled and kept in a separate locked container. **FINDINGS** Bathroom #1 – Unlabeled bottle of latanoprost stored unsecured on bathroom sink	**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 All medications will be stored under proper conditions of sanitation temperature light moisture ventilation segregation and security in accordance with 11-100-1-15(b) Medications will be maintained in their original labeled container and will not be left unlabeled or unattended No medications are required will be stored in resident bathrooms or unsecured area Medication requiring refrigeration will be properly labeled Store in a separate locked container within refrigerator The Primary Care giver ((PCG) will perform daily medication storage check to ensure its compliance	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Physician's order dated 3/14/26 states, "Cholecalciferol (Vit D3) 1 tab AM"; however, dosage to administer not provided. Medication order incomplete Submit a copy of updated physician's order with plan of correction	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Correction The physician/APRN was notified immediately regarding the incomplete order An updated and clarified physician/APRN order was obtained specifying the correct dosage/strength (eg 1000 IU, 2000 IU etc) The Medication Administration Record (MAR) was updated to reflect the complete and accurate order A copy of the updated physician/aprn order will be attached	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Physician's order dated 3/14/26 states, "Cholecalciferol (Vit D3) 1 tab AM"; however, dosage to administer not provided. Medication order incomplete Submit a copy of updated physician's order 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?** Future Plan All medication orders will be reviewed upon receipt to ensure they include complete details (medication name.dosage/ strenght, route, frequency)) No medication will be administered unless the order is complete and clearly defined The Primary Caregiver(PCG) will implement a a medication order verification process prior to transcription onto the MAR Any incomplete or unclear orders will be clarified with the physician/APRN immediately before administration Staff will be re-educated on proper medication order verification and documentation requirements Weekly MAR audits will be conducted to ensure all medication orders are complete and accurately transcribe Any discrepancies will be corrected immediately with follow up and documentation Audit logs and updated physician/APRN orders will be maintained for readiness inspection	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Physician's order dated 3/14/26 for the following medication; however, medication unavailable to administer: • Trazadone • Polyethylene glycol • Loratadine	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Correction The pharmacy and/or responsible party were contacted immediately to obtain the prescribed medications All listed medications (Trazodone Polyethylene Glycol and Loratadine) were obtained and made available for administration without delay The Medication Administration Record (MAR) was reviewed and updated to ensure accurate documentation Any missed doses were reported and addressed per physician/APRN guidance	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Physician's order dated 3/14/26 for the following medication; however, medication unavailable to administer: • Trazadone • Polyethylene glycol • Loratadine	**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 A medication inventory system will be implemented to ensure all prescribed medication are available at all times The Primary Caregiver (PCG) will conduct daily daily medication checks to verify availability of all ordered medications A refill tracking system will be established to reorder medication before supply is depleted Medications will be verified upon receipt of new physician/ APRN orders to ensure immediate availability Staff will be re-educated on timely medication procurement and monitoring responsibilities Weekly audit of medication inventory and MAR will ensure all medications are available and administered as ordered Any discrepancies will be corrected immediately including prompt ordering and documentation	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Per PCG, Ojjaara being administered daily since 3/30/26; however, physician's order unavailable to administer Submit a copy of physician's order with plan of correction	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Immediately upon identification of the deficiency The Primary Caregiver contacted the resident's physician/APRN and obtained a valid medication order (copy of discharge summary) for ojaara The order was reviewed for accuracy and placed in the resident's medical record Administration of the medication is now supposed by his current physician/APRN order. the copy of the order will be submitted with plan of correction	05/04/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Per PCG, Ojjaara being administered daily since 3/30/26; however, physician's order unavailable to administer Submit a copy of physician's order 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?** Future Going forward no medication or supplement will be administered with out a current written physician/APRN order on file prior to initiation The Primary Caregiver will verify all new medication orders before first dose administration and conduct weekly audits of medication records to ensure all prescribed medication have corresponding signed orders in the chart Staff will be re-educated regarding medication order verification requirements	04/29/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Physician's order dated 3/8/26-3/13/26 states, "trihexyphenidyl 2mg Take 2 mg by mouth 2 times a day"; however, "trihexyphenid YL 2mg tab take 2 tabs by mouth 2xs a day" was being administered during this time. Dosage administered did not reflect physician's order.	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 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Physician's order dated 3/8/26-3/13/26 states, "trihexyphenidyl 2mg Take 2 mg by mouth 2 times a day"; however, "trihexyphenid YL 2mg tab take 2 tabs by mouth 2xs a day" was being administered during this time. Dosage administered did not reflect physician's 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?** Future A double check system will be implemented for all and transcribe medication orders to ensure accuracy before administration The Primary Caregiver (PCG) will conduct weekly MAR to order audits to verify consistency between physician/APRN orders and medication administration records All caregivers will undergo ongoing medication management training emphasizing the 5 rights of medication administration (right patient, medication, dose, route and time) Any medication charges or new orders will be reviewed and verified immediately upon receipt before being carried out Documentation procedures will be reinforced to ensure clarity and accuracy in transcription and administration	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Physician's order dated 3/8/26-3/31/26 states, "Polyethylene glycol 3350 17gram pwpk Take 1 Packet by mouth daily. Dissolve in 4-8oz of liquid; Max rec. Tx is 2 weeks (acute) or 6 months (chronic)"; however, per MAR, medication was being made available as "Polyethylene Glycol 3350 Miralax 17g 1 packet daily 4-8oz liquid PRN constipation". Medication was not administered as ordered during this time.	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 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Physician's order dated 3/8/26-3/31/26 states, "Polyethylene glycol 3350 17gram pwpk Take 1 Packet by mouth daily. Dissolve in 4-8oz of liquid; Max rec. Tx is 2 weeks (acute) or 6 months (chronic)"; however, per MAR, medication was being made available as "Polyethylene Glycol 3350 Miralax 17g 1 packet daily 4-8oz liquid PRN constipation". Medication was not administered as ordered during this time.	**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 All medication orders will be carefully transcribed and verified to ensure accuracy in frequency (scheduled vs PRN) dosage, route and instructions A double check system will be implemented when transcribing new or updated orders onto the MAR The Primary Caregiver (PCG) will conduct daily MAR reviews to ensure medications are administered exactly as ordered Staff will be re-educated on the importance of distinguishing scheduled medications vs PRN medication Any discrepancies will be immediately corrected and clarified with the physician/APRN orders prior to administration Weekly MAR audits will be conducted to ensure full alignment between physician/APRN orders and MAR entries Any discrepancies will be corrected immediately with restraining and documentation Audit logs and training records will be maintained for inspection readiness	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Physician's order dated 3/14/26-current states, "Magic Mouth Wash take 1 cup full (4ml) and swish it around the mouth"; however, frequency to administer is unavailable. Medication order incomplete. Submit a copy of updated physician's order with plan of correction	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Correction The physician/APRN was contacted immediately to clarify the incomplete An updated physician/APRN order was obtained including the specific frequency of administration (e.g. BID TID QID or as directed) The Medication Administration Record (MAR) was updated to reflect the complete and accurate order Staff were instructed to administer the medication only per the updated order	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Physician's order dated 3/14/26-current states, "Magic Mouth Wash take 1 cup full (4ml) and swish it around the mouth"; however, frequency to administer is unavailable. Medication order incomplete. Submit a copy of updated physician's order 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?** Future All medication orders will be reviewed upon receipt to ensure they include complete details - Medication Name - Dosage/Amount - Route - Frequency No medication will be administered unless the order is complete and clearly defined The Primary Caregiver will implement a medication order verification process prior to transcription onto the MAR Any incomplete or unclear orders will be clarified with the physician/APRN immediately before administration Staff will be re-educated on proper medication order verification and documentation requirements Weekly audits of MAR and Physician/APRN orders will ensure all medication orders are complete and accurately transcribed Any discrepancies will be corrected immediately with retraining and documentation Audit logs and updated orders will be maintained for inspection readiness	04/20/26

	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 #1 – Per 4/2026 MAR, daily prescribed medications have not been administered since 4/1/26	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Correction Immediate review of the resident's medication orders and MAR was conducted Prescribed medications was restarted immediately as ordered by the physician/APRN The prescribing provider APRN was notified of missed doses for future guidance and monitoring A late entry documentation was completed where appropriate and gaps were clearly identified The caregiver responsible was re educated on proper medication administration and MAR documentation requirements Resident was assessed for any adverse effects related to missed medications with no acute issues noted(or specify if otherwise)	04/20/26

	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 #1 – Per 4/2026 MAR, daily prescribed medications have not been administered since 4/1/26	**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 Implement a daily medication administration audit by the Primary Caregiver (PCG) to ensure all medications are given and documented each shift Establish a shift to shift handoff protocol requiring MAR review and sign off to confirm medication were administered Conduct weekly MAR audits comparing physician/APRN orders with documentation for accuracy and completeness Reinforce mandatory use of the "no documentation not administered standard staff training Provide ongoing medication management in service training to all caregivers including proper documentation practices Any missed medication will be reported immediately to the PCG and provider with incident documentation completed	04/20/26

	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 #1 – Per PCG, Ojjaara is being administered daily since 3/30/26; however, per MAR, no documented evidence medication is being administered 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** Correction: The MAR was reviewed and immediately corrected to reflect accurate medication administration documentation Ojjaara was confirmed to be available and administered as ordered A revised MAR was completed including proper documentation of administration (date time dosage and caregiver's initial) Staff involved were re-educated immediately on proper documentation requirements The physician/APRN was notified as needed regarding documentation discrepancy	04/20/26

	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 #1 – Per PCG, Ojjaara is being administered daily since 3/30/26; however, per MAR, no documented evidence medication is being administered 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?** Future All medications administered will be documented in real time on the MAR w/required elements - Date - Time - Medication Name - Dosage - Caregiver initial A no pre charting /no late charting policy will be reinforced The Primary Caregiver (PCG) will conduct daily MAR reviews to ensure documentation is complete and accurate A shift to shift medication verification in process will be implemented to ensure continuity and proper documentation Staff will be re educated on timely and accurate medication documentation requirements Weekly MAR audits will be conducted to ensure all medication administered are properly documented Any discrepancies will be corrected immediately with retraining and follow up Audit logs and staff training records will be maintained for inspection readiness	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident #1-4 – Initial TB clearance 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** Correction The primary caregiver(PCG) immediately verified TB clearance status for Residents #1-#4 Physician/APRN and or appropriate providers were conducted to obtain TB clearance documentation TB testing (e.g. 2 step skin test or IGRA) was completed or scheduled immediately for any resident without current documentation All obtained TB clearance records were placed in each resident's individual file	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(4) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: A report of a recent medical examination and current diagnosis taken within the preceding twelve months and report of an examination for tuberculosis. The examination for tuberculosis shall follow current departmental policies; **FINDINGS** Resident #1-4 – Initial TB clearance 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?** Future All residents will have a complete admission records including TB clearance prior to or upon admission in accordance with regulatory requirements A resident admission checklist will be implemented to ensure all required documents (medical exam TB clearance Diagnosis) are completed and filed No resident will be admitted with out a verified TB clearance documentation or proof of testing in process per DOH guidelines The PCG will conduct monthly audits of residents records to ensure completeness and compliance Staff will be re-educated on admission requirements and documentation standard Quarterly record audits will be conducted to ensure all residents files contain current and complete TB clearance documentation Any missing documentation will be corrected immediately upon identification Audit logs and updated records will be maintained for inspection readiness	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(8) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: A current inventory of money and valuables. **FINDINGS** Resident #1 – Inventory of possessions unavailable for admission on 3/8/26 Submit a copy of current inventory with plan of correction	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Correction A current inventory of Resident #1 Money and personal belongings was completed immediately The inventory includes all valuables personal items and any money held or managed by the facility The completed inventory was reviewed with the resident and or responsible party and signature was obtained The document was placed in the resident's record	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (a)(8) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review: A current inventory of money and valuables. **FINDINGS** Resident #1 – Inventory of possessions unavailable for admission on 3/8/26 Submit a copy of current inventory 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?** Future An inventory of money and valuables will be completed upon admission for all residents The inventory will be updated as needed (e.g. upon changes transfers or discharge) A standerizred inventory form will be used consistently for all residents The Primary Caregiver (PCG) will ensure completion and filing inventory documentation at admission Staff will be re educated on admission documentation requirements including inventory of valuables monthly audits of resident records will verify that all required admission documents including inventory forms are complete on file Any missing documentation will be completed immediately upon identification Audit logs and signed inventory forms will be maintained for inspection readiness	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; **FINDINGS** Resident #1-4 – Current TB clearance 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** Correction TB clearance for resident #1-#4 has been requested immediately from their respective physician/APRNs Appointments for TB screening (PPD/IGRA or chest x ray as applicable) have been scheduled/completed Copies odf completed TB clearance results will be submitted and place in each resident's records upon receipt Existing records were reviewed to ensure no other required documentation is missing	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; **FINDINGS** Resident #1-4 – Current TB clearance 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?** Future Plan A tracking system /log will be implemented to monitor all residents' TB clearance due dates annually The Primary Caregiver (PCG) will conduct monthly charts audits to ensure all required documents including TB clearance are current and on file TB re-evaluation will be schedules at least 30 days prior to expiration to prevent lapses A compliance checklist will be maintained in each resident's chart to verify completion of all required records Staff will be re-educated on regulatory requirements regarding timely documentation and record maintenance	04/20/26

	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 do not include resident's observed response to medications and diet	**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 do not include resident's observed response to medications and diet	**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 A standerized progress note template will be implemented to ensure inclusion of -Responses to medication -Responses to treatments -Dietary intake and tolerance -Changes in condition -Behavior patterns and interventions The Primary Caregiver (PCG) will perform monthly chart audits to ensure all required element are documented Staff will recieve on going in service training on proper documentation of PRNmedications and regulatory requirements	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; **FINDINGS** Resident #1 – Resident administered guaifenesin PRN for cough multiple times daily from 1/18/26-1/25/26; however, resident's response to PRN treatment not documented	PART 1 **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; **FINDINGS** Resident #1 – Resident administered guaifenesin PRN for cough multiple times daily from 1/18/26-1/25/26; however, resident's response to PRN treatment not documented	**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 A PRN documentation protocol will be implemented requiring -Indication/reason for PRN use -Time of administration -Resident's response/effectiveness within a specified timeframe The MAR will include a designated section for PRN effectiveness documentation The Primary caregiver(PCG) will conduct weekly audits of PRN medication administration and documentation All caregivers will receive on going in service e training on documentation standards emphasizing that PRN medications must always include follow up response documentation A shift end verification process will be implemented to ensure all PRN medications given during the shift have corresponding documentation od effectiveness	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; **FINDINGS** Resident #1 – Resident administered guaifenesin PRN for cough multiple times daily from 1/18/26-1/25/26; however, no documented evidence resident's condition was monitored or if/when resident's condition returned to baseline	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(3) During residence, records shall include: Progress notes that shall be written on a monthly basis, or more often as appropriate, shall include observations of the resident's response to medication, treatments, diet, care plan, any changes in condition, indications of illness or injury, behavior patterns including the date, time, and any and all action taken. Documentation shall be completed immediately when any incident occurs; **FINDINGS** Resident #1 – Resident administered guaifenesin PRN for cough multiple times daily from 1/18/26-1/25/26; however, no documented evidence resident's condition was monitored or if/when resident's condition returned to baseline	**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 A PRN monitoring and documentation protocol will be implemented requiring -Reason for PRN administration -Time administered Follow up assessment of effectiveness -Ongoing monitoring of condition -Documentation of return to baseline or need for further intervention A standardized progress note template will be utilized to ensure all required elements are consistently documented The Primary Caregiver (PCG) will conduct weekly audits of PRN use and documentation to ensure compliance Staff will receive on going in service training emphasizing that all changes in condition and resolution back to baseline must be clearly documented A shift end documentation check will be implemented to verify that all PRN administrations include follow up and out come documentation	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(8) During residence, records shall include: Notation of visits and consultations made to resident by other professional personnel as requested by the resident or the resident's physician or APRN; **FINDINGS** Resident #1 – Physician's visit on 3/9/26 was not documented in progress notes	**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)(8) During residence, records shall include: Notation of visits and consultations made to resident by other professional personnel as requested by the resident or the resident's physician or APRN; **FINDINGS** Resident #1 – Physician's visit on 3/9/26 was not documented in progress notes	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Future A professional visit log will be Implemented to track all physician/APRN and other healthcare provider visits The Primary Caregiver (PCG) will ensure that same day documentation of all visits and consultations is completed in the progress note A documentation checklist will be added to each resident's chart to ensure all required entries including outside professional visits are completed The PCG will conduct monthly chart audits to verify that all visits and consultations are properly documented Staff will receive on going in service training on documentation requirements emphasizing timely and complete recording of all professional interactions	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (f)(2) General rules regarding records: Symbols and abbreviations may be used in recording entries only if a legend is provided to explain them; **FINDINGS** Resident #1 – Initials used to sign off on monthly MARs not reflected on MAR legend to identify name of initialer Submit a copy of updated MAR legend with plan of correction	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Corrected - The MAR legend was updated immediately to include the full names and corresponding initials of all caregivers administering medications All current staff signatures/initials were reviewed and verified for accuracy the updated MAR legend was attached to the resident's MAR and made readily accessible for reference Caregivers were re educated on the requirements to ensure their initials are clearly identified in the MAR legend prior to signing medication entries	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (f)(2) General rules regarding records: Symbols and abbreviations may be used in recording entries only if a legend is provided to explain them; **FINDINGS** Resident #1 – Initials used to sign off on monthly MARs not reflected on MAR legend to identify name of initialer Submit a copy of updated MAR legend 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?** Future A standardized MAR legend form will be maintained and updated with any staffing changes The Primary Caregiver (PCG) will ensure that no caregiver administers or initials medications with out first being listed on the MAR legend monthly MAR audit will be conducted to verify that all initials correspond with the legend Staff will receive on going in service training regarding proper MAR documentation and regulatory requirements The MAR legend will be reviewed and updated immediately upon hiring termination or change of staff	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (f)(4) General rules regarding records: All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency. **FINDINGS** Resident #1 – Admission assessment dated 3/9/26 has not been signed by resident/resident representative Submit a signed copy with plan of correction	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Correction The admission assessment was reviewed with the resident and or resident representative the required signature was obtained immediately completing the document The signed admission assessment was placed in the resident's file and made readily available for review A copy of the signed admission assessment is attached with the Plan of correction	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (f)(4) General rules regarding records: All records shall be complete, accurate, current, and readily available for review by the department or responsible placement agency. **FINDINGS** Resident #1 – Admission assessment dated 3/9/26 has not been signed by resident/resident representative Submit a signed 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?** Future All admission documents will be reviewed for completeness at the time of admission including required signatures A standardized admission checklist will be implemented to ensure all forms are complete signed and filed prior to finalizing admission The Primary Caregiver (PCG) will verify that all records are complete accurate and current before filling Staff will be re educated on documentation completeness requirements	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** Resident #1 – Discharge on 2/25/26 and readmission on 3/8/26 not documented in resident register Submit a copy of updated resident register with plan of correction	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Correct The permanent resident register was reviewed and updated immediately to include: - Discharge date 02/25/26 - Readmission date 03/08/26 Entries were verified for accuracy and completeness The updated register is maintained and readily available for review a copy of updated resident register is attached	04/20/26

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (h)(1) Miscellaneous records: A permanent general register shall be maintained to record all admissions and discharges of residents; **FINDINGS** Resident #1 – Discharge on 2/25/26 and readmission on 3/8/26 not documented in resident register Submit a copy of updated resident register 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?** Future All admissions discharges and readmissions will be documented in the resident register on the same day occurrence A resident register log/checklist will be implemented to ensure timely entries The Primary caregiver (PCG) will be responsible for maintaining and verifying the accuracy of the register Staff will be re educated on proper documentation requirements for admissions and discharges monthly audits of the resident register will ensure all entries are complete accurate and current Any discrepancies will be corrected immediately with restraining and follow up Audit logs and updated registers will be maintained for inspector readiness	04/20/26

	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 – Resident financial agreement for admission on 3/8/26 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** Correction The resident financial agreement was completed/retrieved immediately The agreement was reviewed and explained to the resident and or resident representative Required signatures were obtained from the Primary Caregiver (PCG)and the resident/resident representative The completed agreement was place on the resident's file A copy of the signed financial agreement is attached with this plan of correction	04/20/26

	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 – Resident financial agreement for admission on 3/8/26 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?** Future All resident will have a completed and signed financial agreement upon admission The agreement will clearly outline the condition under which the PCG manages funds or property A standardized admission checklist will be implemented to ensure financial agreement agreements are completed and filed The Primary Caregiver (PCG) will verify that all required financial documentation is complete accurate and current Staff will be re-educated on requirements Monthly audits of resident records will ensure all financial agreements are complete signed and on file Any missing documentation will be completed immediately upon identification Audit logs and signed agreements will maintained for inspection readiness	04/20/26

	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 – No documented evidence resident was notified of their rights and responsibilities as evidenced by signed documentation for admission on 3/8/26 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** Correction The resident Rights and Responsibilities policy was reviewed and explained to the resident and or resident representative A signed acknowledgment was obtained immediately confirming that the resident was informed of their rights responsibilities and house rules The signed document was placed in the resident's file	04/20/26

	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 – No documented evidence resident was notified of their rights and responsibilities as evidenced by signed documentation for admission on 3/8/26 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?** Future All residents will be informed orally and or in writing of their rights and responsibilities prior to or at admission A signed acknowledgment form will be obtained and filed for every resident upon admission A standardized admission checklist will be implemented to ensure this requirement is completed before finalizing admission The Primary Caregiver (PCG) will verify that documentation of resident rights acknowledgment is complete and current Staff will be re-educated on resident rights requirement Monthly Audits of resident records will ensure all resident have signed acknowledgement of rights and responsibilities on file Any missing documentation will be completed immediately upon identification Audit logs and signed forms will be maintained for inspection readiness	04/20/26

	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 notified in writing of services to be provided and rate for such services for admission on 3/8/26 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** Correction On review of the resident's admission record the required written disclosure form outlining services provided and applicable rates was completed and signed by the resident's responsible party A copy was placed in the resident's. chart and another copy was provided to the family /representative	04/20/26

	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 notified in writing of services to be provided and rate for such services for admission on 3/8/26 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?** Future Plan Effective immediately all admissions and readmission will receive written notice of services rates and any conditional charges prior to or at the time od admission Signed acknowledge by the resident and/or responsible party will be obtained and filed in the resident record The Primary Caregiver will use a standardized admission packet and checklist to ensure all required documents are completed timely Quarterly record audits will be conducted to monitor ongoing compliance	04/29/26

Licensee's/Administrator's Signature: Fides Delgado

Print Name: Fides Delgado

Date: 04/21/26

Licensee's/Administrator's Signature: Fides Delgado

Print Name: Fides Delgado

Date: 04/29/26

Licensee's/Administrator's Signature: Fides Delgado

Print Name: Fides Delgado

Date: 05/04/26