

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: A.C.T.G. ARCH #3	CHAPTER 100.1
Address: 1453 Uila Street, Honolulu, Hawaii 96818	Inspection Date: December 1, 2015 Annual

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p><b>FINDINGS</b> [REDACTED] <b>PROVIDE A COPY OF THE ATTESTATION FORM WITH YOUR PLAN OF CORRECTION.</b></p>	<p>[REDACTED]</p> <p>IN THE FUTURE I WILL USE CHECKLIST TO REMIND ME THAT ALL POSITIVE TB TEST REQUIRE AN ATTESTATION FORM. I WILL ALSO SEND A COPY OF THE ATTESTATION W/ THE RESIDENT WHEN THEY GO FOR THEIR PHYSICALS.</p>	12-28-15
<input checked="" type="checkbox"/>	<p>§11-100.1-17 Records and reports. (b)(1) During residence, records shall include:</p> <p>Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis;</p>		

	Rules (Criteria)	Plan of Correction	Completion Date
	<b>FINDINGS</b> 	 IN THE FUTURE, I WILL TRAIN A SUBSTITUTE TO DOUBLE CHECK MY MAR'S AT THE START OF EACH MONTH TO ENSURE THAT IT IS CORRECTLY COPY FROM MONTH TO MONTH	12-28-15

Licensee/Administrator's Signature:

Print Name:

Date: 12-28-15