Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Lusitana	CHAPTER 100.1
Address: 1925 Lusitana Street, Honolulu, Hawaii 96813	Inspection Date: July 11, 2017 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.

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Rules (Criteria)	Plan of Correction	Completion Date
§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. FINDINGS SCG #1 – No documented evidence of annual tuberculosis clearance. SCG #2 – No documented evidence of initial tuberculosis clearance.	PART 1 DID YOU CORRECT THE DEFICIENCY? USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY - SCG # i got his TB clearance in Ougust 28, 26, 17. - SCG # 2 - Lie Met applicable lecause shik not a SCG, and she's inly 15 years led	
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Rules (Criteria)	Plan of Correction	Completion
	PART 2 FUTURE PLAN USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN? - & will make a checklist of the requirements for the caregivers and put it in my calendar to rem me if their due data. - & will ask my SCG's to keep track in the calendar, check at least ince a month.	Date
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Licensee's/Administrator's Signature:

Print Name: CAROLTN DE GM2 MAN

Date: 11/28/2017

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