

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name: JRR ARCH</b>	<b>CHAPTER 100.1</b>
<b>Address: 94-564 Anaaina Place, Waipahu, Hawaii 96797</b>	<b>Inspection Date: May 9, 2018 Annual</b>

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

**YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE WITHOUT YOUR RESPONSE.**

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DOH-OHCA  
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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (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:</p> <p>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;</p> <p><u>FINDINGS</u>  Resident #1 – No tuberculosis clearance prior to admission.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>Patient Has appointment on May 31, 2018 with his PCP i make sure that PCP will sign &amp; dated the form &amp; must fill up the form.</i></p>	<p style="text-align: center;"><i>5-21-18</i></p> <p style="text-align: center;">'18 MAY 21 P1:07</p> <p style="text-align: center;">STATE OF HAWAII  DOH-CHCA  STATE LICENSING</p>

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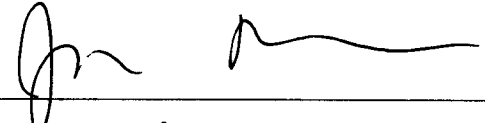
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Licensee's/Administrator's Signature: \_\_\_\_\_



Print Name: \_\_\_\_\_

JEAN RAMIRO

Date: \_\_\_\_\_

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