Office of Health Care Assurance

**State Licensing Section**

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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| **Facility's Name: ALFE II** | **CHAPTER 100.1** |
| **Address:**<br>**1214 Kukila Street, Honolulu, Hawaii 96818** | **Inspection Date: November 1, 2018 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. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-84 Admission requirements. (b)(4)<br>Upon admission of a resident, the expanded ARCH licensee shall have the following information:<br><br>Evidence of current immunizations for pneumococcal and influenza as recommended by the ACIP; and a written care plan addressing resident problems and needs.<br><br>**FINDINGS**<br><br>Resident #1 no evidence of resident receiving or refusing the pneumococcal immunization. | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** | |

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-84 Admission requirements. (b)(4)<br>Upon admission of a resident, the expanded ARCH licensee shall have the following information:<br><br>Evidence of current immunizations for pneumococcal and influenza as recommended by the ACIP; and a written care plan addressing resident problems and needs.<br><br>**FINDINGS**<br><br>Resident #1 no evidence of resident receiving or refusing the pneumococcal immunization. | **PART 2**<br><br>**FUTURE PLAN**<br><br>**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: _____