

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Golden Age Health Care	CHAPTER 100.1
Address: 94-1141 Lumiauau Street, Waipahu, Hawaii 96797	Inspection Date: March 12, 2019 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
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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.</p> <p><u>FINDINGS</u> HHM#1, HHM#2, HHM#3 – No record of negative two-step tuberculosis skin test available for review.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	<p>§11-100.1-15 <u>Medications</u>. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><u>FINDINGS</u> Resident #1 – 7/3/19 Physician’s order reads Acetaminophen Pain Reliever 325mg. Take two tabs by mouth four times per day PRN for pain and/or fever (temp <100.4). However, Medication Administration Record reflects order of Acetaminophen Pain Reliever 325mg. Take one tab by mouth four times a day PRN for pain and/or fever (temp <100.4) for the following dates: 7/3/18 through 7/30/18 and 9/1/18 through 1/29/18.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____