Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: A.C.T.G. Gallegos IV	CHAPTER 100.1
Address: 1530 Piikea Street, Honolulu, Hawaii 96818	Inspection Date: March 8, 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.

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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** PCG – No record available of negative subsequent chest x-ray following positive tuberculosis skin result. HHM#1 – No record of initial 2-step tuberculosis skin test available for review.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** PCG - Staff called MD's office and asked them to fax a copy of my negative chest x-ray. (please see attached copy) HHM#1 - called and made an appointment for TB skin test. Completed skin test step 2 (please see attached copy)	 4/2/19 4/6/19

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Licensee's/Administrator's Signature: ________________

Print Name: Hylen M. Nunez

Date: 4/6/19

Licensee's/Administrator's Signature: ________________

Print Name: HYLEN M. NUNEZ

Date: 5-15-2019

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