Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Galamgam, Crescencia (ARCH)	**CHAPTER 100.1**
Address: **94-1278 Peke Place, Waipahu, Hawaii 96797**	**Inspection Date: October 8, 2021 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) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	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** Substitute Caregiver #1 – Annual TB clearance unavailable for review. Last documented TB clearance was dated 9/2/20.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, substitute caregiver #1 Annual PB clearance done dated 10/14/21. Copy of result is enclosed STATE OF HAWAII DEPT OF HEALTH STATE LICENSING '21 OCT 21 P2:13	10/14/21

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STATE OF HAWAII
DEPT OF HUMAN SERVICES
STATE LICENSING
'21 OCT 21 P2:13

Licensee's/Administrator's Signature: C Galangan

Print Name: Crescencia R. Galangan

Date: October 18, 2021