Office of Health Care Assurance

**State Licensing Section**

# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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|---|---|
| **Facility's Name: Carmelita's** | **CHAPTER 100.1** |
| **Address:**<br>**94-1020 Hapapa Street, Waipahu, Hawaii 96797** | **Inspection Date: November 7, 2024 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 PER HAR 11-100.1-3(e)(2). IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

**FAILURE TO CORRECT CITED DEFICIENCIES AS PER THE PLAN OF CORRECTION COULD RESULT IN REFUSAL TO RENEW YOUR LICENSE PER HAR 11-100.1-3(e)(3).**

| | RULES (CRITERIA) | PLAN OF CORRECTION | Completion Date |
|---|---|---|---|
| ☒ | §11-100.1-15 Medications. (e)<br>All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.<br><br>**FINDINGS**<br>Resident #1 – Physician ordered "Acetaminophen 325mg tablet, take 1 tablet PO every 4 hours as needed for pain, NTE 4 doses a day" & "Ibuprofen 200mg tablet, take 1 tablet PO as needed for testicular pain, NTE 2 doses a day." Both medications are not available in facility for resident use. | **PART 1**<br><br>**DID YOU CORRECT THE DEFICIENCY?**<br><br>**USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** | |

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____