

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Golden Life Hawai'i LLC	Chapter: 100.1
Address: 94-881 Kahualua Street, Waipahu, Hawaii 96797	Inspection Date: May 21, 2026 Relicensing Inspection

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.

RULE (CRITERIA)	PLAN OF CORRECTION	Completion Date
<p>§11-100.1-9 Personnel, staffing and family requirements. (b)</p> <p>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></p> <p>Substitute Care Giver #1 – No documented evidence that a 2-step TB test was completed.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p>	

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Licensee's/Administrator's Signature:

Print Name:

Date: