Foster Family Home - Corrective Action Report

Provider ID: 5-100038

Home Name: Marysol Ganotisi, CNA

4212 Helii Place

Lihue HI 96766

Review ID: 5-100038-4

Reviewer: [redacted]

Begin Date: 1/13/2015 End Date: 1/13/15

Foster Family Home **Required Certificate** **[17-1454-6]**

6.(d)(1) Comply with all applicable requirements in this chapter; and

Comment:

6.(d)(1)
Review for recertification. Former SCG added back on as SCG. All items submitted on date of review.

Foster Family Home **Personnel and Staffing** **[17-1454-41]**

41.(f)(1) Tuberculosis clearances that meet department of health guidelines; and

Comment:

41.(b)(5)(C)(ii)
Results of CG #3's TB test (already done) to be submitted.

[redacted] CM
Compliance Manager

2/28/15
Date

Primary Care Giver

03.05.15
Date

DEFICIENCY:

[redacted] (CG #3 [redacted]) TB Test Results

HOW DID YOU CORRECT THIS DEFICIENCY?

CG #3 [redacted] [redacted] went to the Department of Health to have [redacted] TB Test done.

HOW WILL YOU AVOID COMMITTING THIS DEFICIENCY IN THE FUTURE?

As the Primary Caregiver i will make sure that all my SCG's and HHM's including myself that all the required paperworks are all updated and ill make sure that we will renew it before the renewal date.

03.06.15

Marysol Ganofsi