Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: **Manayan's ARCH-EC-LLC**	**CHAPTER 100.1**
Address: **1319 Gulick Avenue, Honolulu, Hawaii 96819**	**Inspection Date:** **November 7, 2016 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.

	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 care giver #3 No documentation of initial positive PPD.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** secure a document for evidence of positive skin test. copy attach	11-7-16

	Rules (Criteria)	Plan of Correction	Completion Date
☒	RULE # §11-100.1-9 (b)	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** I will not hire a substitute caregiver with out complete tuberculosis document.	11-7-16

Licensee's/Administrator's Signature: Florence Manayan

Print Name: Florence Manayan

Date: 1-30-17