

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

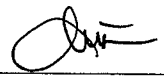
Facility's Name: Debora's	CHAPTER 100.1
Address: 1773 Piikea Street, Honolulu, Hawaii 96818	Inspection Date: August 5, 2016 Annual

RECEIVED

'16 SEP 30 AM 11:47

STATE OF HAWAII  
DEPARTMENT OF HEALTH CARE LICENSING

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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.</p> <p><b>FINDINGS</b> Substitute care giver #4 No documentation of annual TB clearance.</p>	<p><b>WHAT DID YOU DO TO CORRECT THE DEFICIENCY?</b> SCG advised that she needs to have TB clearance from her PMD, required by DPH for her to remain SCG. Copy of annual TB clearance obtained on 8/27/16. Copy Enclosed.</p> <p><b>FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b> Family members and SCG's TB clearance schedules already written on CTO's daily calendar schedule to avoid same mistake again.</p>	<p>8/27/16</p> <p>8/27/16</p>

Licensee's/Administrator's Signature: 

Print Name: Debara Castro / Debaris EC-ARCH

Date: 8 / 29 / 16