

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: C.A.R.E. Cottage – Hilo #2	CHAPTER 98
Address: 100 Apoke Street, Hilo, Hawaii 96720	Inspection Date: April 21, 2017 Annual April 21, 2017 Sanitation

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
<input checked="" type="checkbox"/>	<p>§11-98-11 <u>Minimum standards for licensure: personnel. (e)</u> There shall be documented evidence that every employee has a pre-employment and an annual health evaluation by a physician. These evaluations shall be specifically oriented to determine the presence of any infectious disease liable to harm a resident. Each health evaluation shall include a tuberculin skin test or a chest x-ray.</p> <p>FINDINGS Staff #1, date of hire: <u>May 16, 2016</u>. Two (2) step tuberculosis (TB) skin test completed on <u>June 8, 2016</u>. TB skin test completed after hire.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;">Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

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	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-98-11 <u>Minimum standards for licensure, personnel.</u> (1) The administrator shall see that at least one staff member on each shift possesses a current First Aid certificate and CPR training. Recertification of training shall be required by all staff at least every two years.</p> <p><u>FINDINGS</u> Staff #1, no first aid and cardiopulmonary resuscitation (CPR) certification.</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> <p>CPR/FIRST AID card requested from Staff #1 on 04/21/17. Since no card was furnished, Staff member taken off the schedule 9/11/17.</p>	<p style="text-align: center;">4/21/17 9/11/17</p>

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	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-98-14 <u>Physical facility.</u> (c) Maintenance. Facilities shall be maintained in accordance with provisions of state and county zoning, building, fire, safety and health codes in the State.</p> <p><u>FINDINGS</u> Kitchen microwave – inside surface dirty.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>RCM/maintenance cleaned Kitchen microwave.</p>	<p>4/21/17</p>

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<input checked="" type="checkbox"/>	<p>§11-98-14 <u>Physical facility.</u> (c) Maintenance. Facilities shall be maintained in accordance with provisions of state and county zoning, building, fire, safety and health codes in the State.</p> <p><u>FINDINGS</u> Trash can - no tight fitting lid.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Trashcan removed from service</p>	<p>4/22/17</p>

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Licensee's/Administrator's Signature:



Print Name:

Sherrice Perry-Jones

Date:

12/20/17