

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Cabingabang Care Home	CHAPTER 100.1
Address: 94-1121 Waipahu Street, Waipahu, Hawaii 96797	Inspection Date: July 26, 2017 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
<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><u>FINDINGS</u></b>  FM #1 – No annual tuberculosis clearance.</p>	<p style="text-align: center;"><b>PART 1</b>  <b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>FM # 1 - HAS TUBERCULOSIS CLEARANCE BUT MISSING ON FILE  - REQUESTED COPY FROM PEP FOR MY FILE  COPIES ENCLOSED</p>	<p style="text-align: center;">7/27/17</p> <p style="text-align: right; font-size: small;">STAFF 3</p>

	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><u>FINDINGS</u>  FM #1 – No annual tuberculosis clearance.</p>	<p style="text-align: center;"><b>PART 2</b>  <u><b>FUTURE PLAN</b></u></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>TO ENSURE THAT IT DOESNT HAPPEN AGAIN I WILL MAKE AND CHECK MY CHECKLIST TO REMIND ME AND COMPLETE REQUIRED DOCUMENTS.</p>	<p>3/12/18</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation.</u> (c) Refrigerators shall be equipped with an appropriate thermometer and temperature shall be maintained at 45°F or lower.</p> <p><b>FINDINGS</b> Refrigerator temperature not 45°F or lower. Two (2) refrigerator thermometers read 48°F and 50°F.</p>	<p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p>- REFRIGERATOR TEMPERATURE WAS ADJUSTED TO 45°F AND MAINTAINED.</p>	<p>7/27/17</p>

	Rules (Criteria)	Plan of Correction	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-14 <u>Food sanitation:</u> (c) Refrigerators shall be equipped with an appropriate thermometer and temperature shall be maintained at 45°F or lower.</p> <p><u>FINDINGS</u> Refrigerator temperature not 45°F or lower. Two (2) refrigerator thermometers read 48°F and 50°F.</p>	<p style="text-align: center;"><b>PART 2</b> <b><u>FUTURE PLAN</u></b></p> <p style="text-align: center;"><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p>- TO ENSURE THAT IT WILL OR DOESN'T HAPPEN AGAIN THERMOMETER MUST BE CHECKED OFTEN AND TEMP. MUST NOT EXCEED 45°F. IT SHOULD BE 45°F OR LOWER.</p>	<p style="text-align: right;">3/12/18</p>

Licensee's/Administrator's Signature: Delia A. Cabingabang

Print Name: ~~DELIA~~ D. CABINGABANG

Date: 11/13/17

STATE OF FLORIDA  
DEPARTMENT OF

11/13/17

Licensee's/Administrator's Signature: Delia A. Cabingabang

Print Name: DELIA D. CABINGABANG,

Date: 3/12/18