Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Abbie's	CHAPTER 100.1
Address: 94-579 Apii Place, Waipahu, Hawaii 96797	Inspection Date: May 3, 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
☒	§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** PCG, SCG #1, and FM #1 – No documented evidence of an initial tuberculosis clearance.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** I Submitted 2 STEP TB CLEARANCES FOR MYSELF, MY SUBSTITUTE AND FAMILY MEMBER I HAVE PUT A COPY OF EACH IN MY CARE HOME BINDER SO THAT IT WILL BE EASILY AVAILABLE FOR THE DEPARTMENT TO REVIEW	9/6/17

	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** PCG, SCG #1, and FM #1 – No documented evidence of an initial tuberculosis clearance.	**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 DOCUMENT A REMINDER FOR MYSELF TO UPDATE THE REQUIREMENTS IN MY CARE HOME THE REMINDER WILL BE KEPT IN MY CARE HOME BINDER AND A CHECKLIST FOR STAFF/FAMILY REQUIREMENT COPIES OF BOTH ARE ENCLOSED	ONGOING

Licensee's/Administrator's Signature: [signature]

Print Name: FLORECITA I. PERALTA

Date: 1/16/18

Licensee's/Administrator's Signature: [signature]

Print Name: FLORECITA I. PERALTA

Date: 3/21/18