

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Mely Mueller	CHAPTER 100.1
Address: 94-949 Lumiloke Street, Waipahu, Hawaii 96707	Inspection Date: April 24, 2018 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> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p><u>FINDINGS</u> SCG #1 – No annual physical examination.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I have to make a check list of all clearance and all requirement, put on the calendar 1 month before annual inspection for the next year (month of February)</i> <i>rey</i></p> <p style="text-align: right;">STATE OF HAWAII DOH-DOHA STATE LICENSING</p>	<p style="text-align: right;"><i>1/5/18</i></p> <p style="text-align: right;">18 SEP 18 P2:15</p>

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	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>FINDINGS SCG #1 – No annual tuberculosis clearance.</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><i>I made appt. for (BGG) SCG 5/5/18. Seen Dr. Alvarez for physical examination and MD APR tuberculosis risk assessment. 5/5/18</i> <i>M. Malloy</i></p>	<p style="text-align: center;">5/5/18</p>

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MAY 15 2018

	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> SCG #1 – No annual tuberculosis clearance.</p>	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p style="text-align: center;"><i>I have to make a check list of all clearance and all requirements, put on the calendar 2 months before annual inspection for the next year. (month of February)</i></p> <p style="text-align: right;"><i>ms</i></p>	<p style="text-align: right;"><i>5/5/18</i></p>

Licensee's/Administrator's Signature: MWJ

Print Name: MELY BALLO CAVAG

Date: 5/7/18

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