

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Marina Manuel Care Home	CHAPTER 100.1
Address: 94-1035 Lumikula Street, Waipahu, Hawaii 96797	Inspection Date: April Date, 19 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.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

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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><u>FINDINGS</u> Substitute care giver #1, no evidence of 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>① I corrected the deficiency by having my substitute care giver complete the TB form by her PCP. I obtained a copy of the TB form & kept it for my record 4/25/18</p>	

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Licensee's/Administrator's Signature: Marina Manuel
Print Name: MARINA MANUEL
Date: 4/25/18

Licensee's/Administrator's Signature: Marina Manuel
Print Name: MARINA MANUEL
Date: 10/01/18