

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 25, 2019 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) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (f) The resident and the resident’s family, legal guardian, surrogate or representative shall be informed at the time of admission of all facility policies and procedures</p> <p><u>FINDINGS</u> Resident #1, admitted on <u>3-31-19</u>; signature to verify receipt of the facility policies and procedures obtained on <u>4-1-19</u>.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (f) The resident and the resident's family, legal guardian, surrogate or representative shall be informed at the time of admission of all facility policies and procedures</p> <p><u>FINDINGS</u> Resident #1, admitted on <u>3-31-19</u>; signature to verify receipt of the facility policies and procedures obtained on <u>4-1-19</u>.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p>	

Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____