

Office of Health Care Assurance  
State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Yamashiro Care Home L.L.C.	CHAPTER 100.1
Address: 45-386 Kanehameha Highway, Kaneohe, Hawaii 96744	Inspection Date: September 16, 2021 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"/> §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.  <b>FINDINGS</b> Substitute care giver #1: No documented evidence of annual tuberculosis clearance.	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><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> <i>Instructed caregiver #1 to go to local health center to complete application for TB test and have nurse administer skin test. Then return 48 to 72 hours to read (measure) induration. TB clearance was obtained on 9/20/21 and it is now in file.</i> </p>	<p style="text-align: center;"><i>9/20/21</i></p>

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04/16/16, Rev 09/09/16, 04/16/18

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Licensee's/Administrator's Signature:

*Marilyn West*

Print Name:

Marilyn West

Date:

9/20/21

ENGINEERING  
STATE OF TEXAS  
11/11/11

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