

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION


Facility's Name: Salvador, Catherine (ARCH/Expanded ARCH)	CHAPTER 100.1
Address: 2318 Awapuhi Street, Hilo, Hawaii 96720	Inspection Date: November 15, 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.

	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 (SCG) #1 with a history of past positive tuberculosis (TB) skin test – no current TB 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>On Nov 17, 2021, substitute caregiver # 1 went to see primary physician to obtained the TB Risk Assessment and Attestation screening form. And I filed it to my carehome binder.</i></p>	<p><i>11-17-21</i></p>

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Licensee's/Administrator's Signature: 

Print Name: CATHERINE SALVADOR

Date: 11-30-21