

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Flojo Quality Affordable Care Home	CHAPTER 100.1
Address: 1159 Kuokoa Street, Pearl City, Hawaii 96782	Inspection Date: February 16, 2023 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.

STATE OF HAWAII
DEPARTMENT OF HEALTH
STATE LICENSING

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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> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p>FINDINGS Substitute Care Giver (SCG) #1 – No documented evidence of current first aid certification.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u> <u>YES</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>I called the instructor (Rosie Pacheco) on 2/16/2023 and made appointment for SCG # 1 for First Aid Certification class on Feb. 20, 2023.</p> <p>Class instruction for SCG #1 on First Aid Certification was held and completed on February 20, 2023.</p> <p>See attached certificate.</p>	<p style="text-align: center;">2/24/2023</p> <p style="text-align: center;">23 FEB 27 P 3:33</p>

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Licensee's/Administrator's Signature: CAMMAYO

Print Name: CELVIA B. PLATO

Date: 2/24/2023

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STATE OF IOWA
DIVISION OF
STATE LICENSING