

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 Kamehameha Highway, Kaneohe, Hawaii 96744	Inspection Date: September 12, 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.**

RECEIVED  
STATE LICENSING SECTION  
OCT 16 2023  
P 3 51

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§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.</p> <p><b>FINDINGS</b> Resident #1: No documented evidence of annual tuberculosis clearance.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b> <i>yes</i></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>Notified wife of Annual TB clearance being past due (expired) Appointment was made at Stramb Medical Center. PPD test was given on @ forearm on 9/16/23 and read on 9/20/23 Reading 0mm negative.</i></p>	<p><i>9/20/23</i></p> <p style="text-align: center;">23 OCT 16 P 3 51</p> <p style="text-align: center;">STATE OF MA DEPT. OF STATE LICENSING</p>

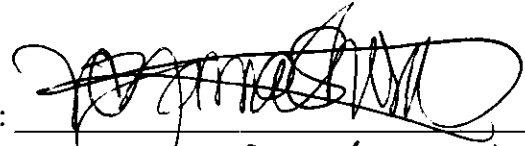
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STATE OF RHODE ISLAND  
DEPARTMENT OF HEALTH  
STATE LICENSING

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 Physical environment. (g)(3)(1)(i) Fire prevention protection. Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either: For each such non-certified resident there must be a responsible adult on the premises of the home at all times that the non-certified resident is present in the home, and there must never be a stairway which must be negotiated for emergency exit by such non-certified resident;</p> <p><b>FINDINGS</b> Resident #1, Resident #2, Resident #3: a total of three (3) non-certified residents in care home.</p>	<p style="text-align: center;"><b>PART 1</b></p> <p style="text-align: center;"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b> <i>Y/S</i></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>Called Dr. Barry &amp; informed her of incorrect status on residents self preservation form. Dr Barry updated &amp; corrected form &amp; faxed to Yamashiro Care home</i></p> <p><i>There are currently two non self preserving residents in Yamashiro care home</i></p> <div style="text-align: right;">  </div>	<p><i>9/12/23</i></p> <p style="text-align: right;">OCT 16 P 3:51</p>

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Licensee's/Administrator's Signature: \_\_\_\_\_



Print Name: \_\_\_\_\_

Vivian C. Yamashiro

Date: \_\_\_\_\_

10/3/23

STATE OF HAWAII  
DENISE H. HANAU  
STATE LICENSING

23 OCT 16 P3:51