

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Aurora's	CHAPTER 100.1
Address: 91-1112 Kiwi Street, Ewa Beach, Hawaii 96706	Inspection Date: May 14, 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"/> §11-100.1-15 Medications. (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident. <u>FINDINGS</u> Resident #1 – Physician ordered "Acetaminophen 325mg tablet, give 2 tablets PO every 4 hours PRN." No documented indication for when to administer prescribed medication on physician order sheet and medication administration record (MAR).	<p style="text-align: center;">PART I</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>I bring the Physicians sheet order to Dr. Gehring and she corrected the order when to administer the medication correctly and completely, & also check my plan and medication level, track</i></p>	<p style="text-align: right;"><i>5/17-21</i></p>

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RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
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MAY 28 10:04 AM '21

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Licensee's/Administrator's Signature:

Luciana Pellegrino

Print Name:

Aurora Alejandro

Date:

8-25-2021

Licensee's/Administrator's Signature:

Luciana C. Pellegrino

Print Name:

AURORA C. ALEJANDRO

Date:

July 15, 2021

Licensee's/Administrator's Signature:

Luciana Pellegrino

Print Name:

AURORA ALEJANDRO

Date:

5-24-21