

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Padron, Martina (ARCH)	CHAPTER 100.1
Address: 67-361 Farrington Highway, Waialua, Hawaii, 96791	Inspection Date: March 3, 2022 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  
DOH-CHCA  
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>  (a)  All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases.</p> <p><b>FINDINGS</b>  Resident #2: No Documented evidence of annual physical exam.</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></p> <p style="text-align: center;"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p style="text-align: center;"><i>P.E. done by PCP. forms completed.</i></p>	<p style="text-align: center;"><i>3/7/22</i></p>

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Licensee's/Administrator's Signature: Martina Padron

Print Name: MARTINA F. PADRON

Date: 3/20/22

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