Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Gloria V. Atmospera, ARCH	**CHAPTER 100.1**
Address: 3544 Pahoa Avenue, Honolulu, Hawaii 96816	**Inspection Date: June 15, 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.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; **FINDINGS** Substitute Care Giver (SCG) #1 - No documented evidence of current first aid certification on file. **Please provide a copy of a first aid certification.**	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Substitute Caregiver #1 - obtained CPR, AED & First Aid Certification on 6-18-22 (see attached)	yes 6-18-22

STATE OF HAWAII
DEPT. OF HHS
STATE LICENSING

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Licensee's/Administrator's Signature: Gloria V. Atmospera

Print Name: GLORIA V. ATMOSPERA

Date: 7-06-22