

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Ulep, Juanita (ARCH)	CHAPTER 100.1
Address: 2817 Nihi Street, Honolulu, Hawaii 96819	Inspection Date: July 27, 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) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

STATE OF HAWAII
OFFICE OF HEALTH CARE ASSURANCE
STATE LICENSING SECTION

22 AUG 30 10:31

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (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><u>FINDINGS</u> Substitute Caregiver #1 – Initial and annual tuberculosis clearances unavailable for review. Submit a copy with plan of correction.</p>	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p><i>Negative TB test 2 step done and secured.</i></p> <p><i>Negative TB test annual done and secured.</i></p>	<p style="text-align: right;"><i>8-10-22</i></p> <p style="text-align: right;"><i>8-12-22</i></p> <p style="text-align: right;">22 AUG 30 AM 031</p>

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Licensee's/Administrator's Signature: J. Ulep

Print Name: Juanita A. Ulep

Date: August 18, 2022

STATE OF CALIFORNIA
DEPARTMENT OF
STATE LICENSING

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