

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 09, 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-ORCA
MEL LIOPEWAN
MAY 23 3:40

	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><u>FINDINGS</u> Substitute Care Giver (SCG) # 3 – No documented evidence of a current physical examination clearance by a physician or advanced practice registered nurse (APRN).</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 style="text-align: center;"><i>Physical examination obtain on May 20, 2022. See attach copy.</i></p>	<p style="text-align: center;"><i>5/20/22</i></p> <p style="text-align: center;">22 MAY 23 P 3:40</p> <p style="text-align: center;">STATE OF HAWAII DOH-OHCA STATE LICENSING</p>

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Licensee's/Administrator's Signature: Aurora C. Alejandro

Print Name: AURORA C. ALEJANDRO

Date: 5-20-2022

22 MAY 23 P3:40
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DOH/CHCA
STATE LICENSING