

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Rose P. Lee DDD-Home, LLC	CHAPTER 89
Address: 99-838 Hulumanu Street Aiea, Hawaii 96701	Inspection Date: September 21, 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.

STATE LICENSING
SECTION
21 DEC 23 P 4:12

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-14 <u>Resident health and safety standards. (e)(5) Medications:</u></p> <p>All medications and supplements, such as vitamins, minerals, and formulas shall be made available by written physician order and shall be based upon current evaluation of the resident's condition.</p> <p><u>FINDINGS</u> Resident #1 - On 8/2/21, Physician ordered "Furosemide 20mg 1 tab by mouth every morning as needed for swelling", however, medication administration record (MAR) for the month of 9/2021 does not indicate medication is an "as needed" medication and the MAR is initialed as given from 9/1/21 to current.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p>21 DEC 27 P4:12</p>

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STATE LICENSING

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-18 <u>Records and reports.</u> (b)(7) During residence, records shall be maintained by the caregiver and shall include the following information:</p> <p>Recording of resident's weight at least once a month, and more often when requested by a physician;</p> <p><u>FINDINGS</u> Resident #2, #3, & #4 – No documented evidence of monthly weights being taken.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p>21 DEC 27 P 4:12</p> <p>STATE OF WASH DEPT OF COMM STELLINGMA</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-89-19 <u>Nutrition</u>. (a) Meals shall be well-balanced and sufficient in quantity, quality, and variety to meet nutritional requirements of residents and shall be in accordance with the national research council of the national academy of sciences most current recommended dietary allowance (RDA), and adjusted to age, sex, activity, and disability.</p> <p><u>FINDINGS</u> Resident #1 – Please have Physician/APRN clarify diet orders as well as if client should be on both low salt and low calorie diets. On 6/18/21 diet order reads “Low salt”. “Low salt” would need to include amount of salt is allowed such as 2 grams or 3 grams. On 8/24/21 diet order reads “Low calorie”. “Low calorie” diet would need to include the number of calories the resident should be limited to.</p>	<p>PART 1</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>To address the doctor's order regarding low salt and low calorie deficiencies, I have contacted the doctor's office of the resident and asked for additional detailed information.</i></p>	<p><i>12/20/21</i></p> <p><i>12/8/2021</i></p> <p>DEC 27 P4:12</p>

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Licensee's/Administrator's Signature: _____

R. Lee

Print Name: _____

Rose Marie P. Lee

Date: _____

12/20/2021

STATE OF HAWAII
FOR THE
STATE LITIGATING

21 DEC 27 P4:13

Licensee's/Administrator's Signature: *R. Lee*

Print Name: Rose Marie P. Lee

Date: ~~12/20/2021~~ *RL*
2/18/2022

STATE OF MICHIGAN
DEPARTMENT OF
STATE LICENSING

'22 FEB 28 P2:39