Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Lettie's	**CHAPTER 100.1**
Address: **739-D N. Judd Street, Honolulu, Hawaii 96817**	**Inspection Date: July 5, 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
☒	§11-100.1-2 Definitions. As used in this chapter: "Licensed capacity" means the number of residents and the type of residents permitted by the director, pursuant to these rules and chapter 321, HRS, in a particular ARCH or expanded ARCH, and so stated on the particular ARCH's or expanded ARCH's license. **FINDINGS** Resident #3 - Facility is licensed for ambulatory only, however observed resident utilizing wheelchair in the facility.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Resident moved on October 6, '22 to a higher level of care facility	11-08-22 ~~Oct 18, '22~~

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-2 Definitions. As used in this chapter: "Licensed capacity" means the number of residents and the type of residents permitted by the director, pursuant to these rules and chapter 321, HRS, in a particular ARCH or expanded ARCH, and so stated on the particular ARCH's or expanded ARCH's license. **FINDINGS** Resident #3 - Facility is licensed for ambulatory only, however observed resident utilizing wheelchair in the facility.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** In the event a resident need higher level of care & my licensed is for ambulatory only, I have to notify the family to find an appropriate facility for that resident & will give them one month written notice to the family.	11-08-22

'22 NOV 14 P1:53

STATE OF HAWAII
DOH-BHCA
STATE LICENSING

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** Substitute Care Giver #1 - No documented evidence of a tuberculosis clearance from a physician or advanced practice registered nurse (APRN). **Please provide a copy of a signed tuberculosis clearance by a physician or APRN as evidence of completion.**	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Enclosed is a copy of T.B clearance from the doctor	Oct. 3, 2022

'22 OCT -5 P1:37

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (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. **FINDINGS** Substitute Care Giver #1 - No documented evidence of a tuberculosis clearance from a physician or advanced practice registered nurse (APRN). **Please provide a copy of a signed tuberculosis clearance by a physician or APRN as evidence of completion.**	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** my future plan is to make sure get the resident T.B Test 1 month before it expire Write in my Calendar one month before it expire to get it done for Care Giver + substitute	11-08-22

'22 NOV 14 P1:53

STATE OF HAWAII
DOH/SHCA
STATE LICENSING

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-10 Admission policies. (d) The Type I ARCH shall only admit residents at appropriate levels of care. The capacity of the Type I ARCH shall also be limited by this chapter, chapter 321, HRS, and as determined by the department. **FINDINGS** Facility is licensed for ambulatory only, however observed resident utilizing a wheelchair in the facility.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** When a resident need a higher level of care will notify the family, give them 30 days written notice to find a higher level of care facility.	11-08-22

'22 NOV 14 P1:54

STATE OF HAWAII
DOH-HRSA
STATE LICENSING

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-10 Admission policies. (d) The Type I ARCH shall only admit residents at appropriate levels of care. The capacity of the Type I ARCH shall also be limited by this chapter, chapter 321, HRS, and as determined by the department. **FINDINGS** Facility is licensed for ambulatory only, however observed resident utilizing a wheelchair in the facility.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Provide retraining & reviewing the license. I will notify the family and give them 30 days written notice to find a higher level of care facility	11-08-22

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22 NOV 14 P1:54

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (l) Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets. **FINDINGS** Diet ordered by physician on 6/21/2022 states "Reduced fat, salt, concentrated sweets, carbohydrates. Increased fruits and vegetables." No documented evidence that the facility clarified the diet order with physician.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Yes, called her doctor -telephone order for her regular diet Aug. 29, 2022. Enclosed is a copy for Regular diet	Oct. 3, 2022

'22 OCT -5 P1:37

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-13 Nutrition. (l) Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets. **FINDINGS** Diet ordered by physician on 6/21/2022 states "Reduced fat, salt, concentrated sweets, carbohydrates. Increased fruits and vegetables." No documented evidence that the facility clarified the diet order with physician.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Will make sure to ask the physician & clarify the diet order for the resident requiring such diet Going forward I will review all special diet orders to make sure that the diet orders are written in standard form, so it is clear on how to provide the diet If I'm unsure about weather the diet orders need clarification I will consult the Ocha nutritionist for guidance.	11-08-22

STATE OF HAWAII
STATE HOSPITAL
LICENSING
22 NOV 14 P1:54

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; **FINDINGS** Resident #1 & Resident #3 – No documented evidence of a current tuberculosis clearance signed by a physician or APRN. **Please provide a copy of a signed tuberculosis clearance by a physician or APRN as evidence of completion.**	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Went to the doctor for Resident #1 & Resident #3 to have their Physical done & T.B. Test	Oct. 3, 2022

22 OCT -5 P1:37

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; **FINDINGS** Resident #1 & Resident #3 – No documented evidence of a current tuberculosis clearance signed by a physician or APRN. **Please provide a copy of a signed tuberculosis clearance by a physician or APRN as evidence of completion.**	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Resident T.B. + annual physical will write in my Calendar to remind myself one month before it expire to be done 11-08-22	

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'22 NOV 14 P1:54

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; **FINDINGS** Resident #2 – No documented evidence of a current annual physical examination signed by a physician or APRN. **Please provide a copy of a signed annual physical examination by a physician or APRN as evidence of completion.**	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Enclosed are copies of Physical, T.B test signed by their doctors	10-3-2022

'22 OCT -5 P1:38

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-17 Records and reports. (b)(1) During residence, records shall include: Annual physical examination and other periodic examinations, pertinent immunizations, evaluations, progress notes, relevant laboratory reports, and a report of annual re-evaluation for tuberculosis; **FINDINGS** Resident #2 – No documented evidence of a current annual physical examination signed by a physician or APRN. **Please provide a copy of a signed annual physical examination by a physician or APRN as evidence of completion.**	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** Will write in my Calendar to remind me to go and get Physical Exam, T.B. etc One Month before it expire to do the physical + T.B Test	11-08-22

'22 NOV 14 P1:54
STATE OF HAWAII
DCCA OFFICE
STATE LICENSING

Licensee's/Administrator's Signature: Leticia D. Tesoro

Print Name: Leticia D. Tesoro

Date: Oct. 03, 2022

Licensee's/Administrator's Signature: Leticia Tesoro

Print Name: Leticia Tesoro

Date: 11-08-22