Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Roselani Place Assisted Living Facility	**CHAPTER 90**
Address: **88 Papa Avenue, Kahului, Hawaii 96732**	**Inspection Date: July 17, 2025 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.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (b)(3)(A)(v) Services. The assisted living facility shall have policies and procedures relating to medications to include but not be limited to: Self-medication: Residents who self-medicate with prescription drugs or maintain over-the-counter drugs in their units shall have all their medications reviewed by either a registered pharmacist, registered nurse, or physician at least every 90 days. **FINDINGS** Resident #1 self-medicates prescription drugs, but medications were not reviewed by either a registered pharmacist, registered nurse, or physician at least every 90 days between 7/14/24 and 7/17/25.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (b)(3)(A)(v) Services. The assisted living facility shall have policies and procedures relating to medications to include but not be limited to: Self-medication: Residents who self-medicate with prescription drugs or maintain over-the-counter drugs in their units shall have all their medications reviewed by either a registered pharmacist, registered nurse, or physician at least every 90 days. **FINDINGS** Resident #1 self-medicates prescription drugs, but medications were not reviewed by either a registered pharmacist, registered nurse, or physician at least every 90 days between 7/14/24 and 7/17/25.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?**	

Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____