Foster Family Home - Corrective Action Report

Provider ID: 1-561309

Home Name: Corazon Dela Rosa, CNA Review ID: 1-561309-2

4048 Keeka Drive Reviewer:

Honolulu HI 96816 Begin Date: 5/4/2015 End Date: 6/22/2015

Foster Family Home **Required Certificate** [17-1454-6]

6.(d)(1) Comply with all applicable requirements in this chapter; and

Comment:

6.(d)(1) Home visit made on 5/4/2015 for a 3-bed recertification and request change to 2-bed recertification. Corrective action report issued during home visit with corrective action plan due to CTA on 6/4/2015.

6 (d)(1) see applicable sections of this review.

Foster Family Home **Client Care and Services** [17-1454-43]

43.(b) One bed in each home shall be reserved for Medicaid recipients.

Comment:

43.(b)Client #1 changed from Medicaid to Private Pay on Dec. 2014. The Home has no record of attempts to obtain and fill the Medicaid bed.

Compliance Manager 5/4/2015
Date

Corazon B. dela Rosa 5/4/2015
Primary Care Giver Date

6-22-2015

43. (b) Home will meet the requirement to look for one medicaid client each week. Enclose is my referral log In. This will not happen again because the home will make sure this will not happen again in the future.

Corazon B. dela Rosa
4043 Keaka Dr
Honolulu Hi 96818

June 22, 2015