

Foster Family Home - Corrective Action Report

Provider ID: 1-512279

Home Name: Flordelisa Tomas, CNA

94-1187 Halelehua Street

Waipahu HI 96797

Review ID: 1-512279-4

Reviewer: [REDACTED]

Begin Date: 8/20/2015

End Date: 9/24/15

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

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

Comment:

Home visit for a 2 person recertification review made on 8/20/15.
Corrective Action Report issued during home visit with a written plan of correction due to CTA by 9/20/15.

6.(d)(1) - see applicable sections of the review

Foster Family Home Quality Assurance [17-1454-48.1]

48.1.(b) Adverse events shall be reported

Comment:

48.1.(b) No adverse event reported for client#1 for 03/01/15 sore on buttocks and 03/06/15 redness to (L) 5th toe

Foster Family Home Insurance Requirements [17-1454-49]

49.(a)(1) General:

Comment:

49.(a)(1) CG#5 no Liability insurance

Foster Family Home Records [17-1454-52]

52.(c)(5) Medication schedule checklist;

Comment:

52.(c)(5) Client#1 Dr. order for [REDACTED] every day until resolved. Scheduled on MAR at 0800 every day. No signatures for month of August.

52.(c)(5) Client#2 Dr. order and MAR reads for [REDACTED] Medication bottle reads [REDACTED] Client #2 Dr. order for [REDACTED] Medication bottle expired.

[REDACTED]
Compliance Manager

Flordelisa Tomas
Primary Care Giver

8/20/15
Date

9-16-15
Date

1-5-12279

Corrective Action Plan

48.1.(b) Adverse events shall be reported.

Comments:

48.1.(b) No adverse events reported for client #1 for 03/01/15 sore on buttocks and 03/06/15 redness to (L) 5th toe.

I will write and incident report for any redness or wound the patient develops within 24hrs. Created an incident report and fax to CM agency. Attached is incident report.

49.(A) (1) CG #5 no liability insurance.

(a). I will create a checklist for each caregiver to make sure that he/she has all document needed to care for my client.

(b). Documents will be updated annually. Added caregiver to liability insurance. Attached is insurance with CG #5

52.(C)(5) Client #1 Dr. order for [REDACTED] until resolved. Scheduled on MAR at 0800 everyday. No signatures for month of August.

When the [REDACTED] is resolved I will discontinue the medication and note it in my progress notes. I will discontinue it from the MAR, and I will also call the doctors' office to inform that the [REDACTED] is resolved. Inform hospice nurse to clarify medicine order for cream. New orders given. Attached is the clarification order from Saint Francis Hospice.

52.(C)(5) Client #2 Dr. order and MAR reads for [REDACTED]. Medication bottle reads [REDACTED].

I will clarify the order with doctors office and inform them that there can't be arranged in dosage, it will have to be an exact dosage. Attached is the order clarification from the doctors' office.

Client #2 Dr. order and MAR reads for [REDACTED]. Medication bottle reads [REDACTED]. Medication bottle reads [REDACTED]. Client #2 order for [REDACTED]. Medication bottle expired.

I will check to make sure that all medication is not passed the medication date daily. [REDACTED] bottle thrown out. New bottle of medication requested and delivered by pharmacy.