Foster Family Home - Corrective Action Report

Provider ID: 1-589822

Home Name: Rosemary Cayabyab, CNA **Review ID:** 1-589822-3

94-1178 Hoomakoa Street Reviewer:

Waipahu HI 96797 Begin Date: 8/13/2015 End Date: 09/09/15

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

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

Comment:

Recertification visit for 3 client home made on 08/13/15. Corrective action plan issued with plan of correction due by 09/13/2015. See applicable sections in 6.(d)(1)

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

48.1.(b) Adverse events shall be reported

Comment:

48.1.(b)Client #1 ER visit on 07/16/15. No adverse event form completed.

Foster Family Home **Records** **[17-1454-52]**

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

Comment:

52.(c)(5) client #1 Dr.'s and MAR read order for [redacted] 2 tabs per [redacted] every day. Medication bottle label reads [redacted] 1 tab per [redacted] every day

Compliance Manager 8/13/15 Date

Primary Care Giver 8/13/15 Date

8/13/2015 16:28 PM

9/5/15

① Citation # 52.c5

- The Medication log/ medication Dr's order now matches the direction label in Medication bottle.
- I will Immediately alert my case manager/RN and Pharmacy of any discrepancies between medication Order/log and medication bottle for them to review it.

② Citation # 48.1. (b)

- I will Complete ~~Adverse~~ event for all future Client when needed.
- I will write a note to my self and paste it on my Board to remind me for any future Events and prevent from happening again

Sincerely yours,

Rosemary Cayabyab