

# Foster Family Home - Corrective Action Report

Provider ID: 1-513235

Home Name: Hedidia Agbulos, CNA

Review ID: 1-513235-5

99-322 Ahe Ahe Street

Reviewer:

Alea HI 96701

Begin Date: 2/2/2017

End Date: 2/11/17

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 for a 3 bed recertification survey. Corrective Action Report issued during home visit. A written plan of correction is due to CTA by 2/16/17.

Foster Family Home Records [17-1454-52]

52.(c)(2) Client's current individual service plan, and when appropriate, a transportation plan approved by the department;

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

Comment:

52.c.2 Service plan for client #2 is dated 5/17/16, over 6 months. There is no representative signature on service plan. Service plan says no CPR. POLST and face sheet say CPR.

52.c.5 There are three medication discrepancies for client #2. Two over the counter bottle dosages do not match Medication Administration Record and orders. One order and prescription labels do not match the Medication Administration Record

Compliance Manager

Primary Care Giver

*Hedidia Agbulos*

Date

*2/02/17*

Date

clients up & out of

substitute caregivers are trained to be alert & aware to a given situation. Be familiar for information & instructions on how to care & safety of our clients. We should always be aware what belongs to our clients. We should coordinate w/ the RN CM & health care provider implementing the Service Plan. We should be fully knowledgeable about the Service Plan content.

The house has now a tracking log for due dates caregiver (flexible) will always be thankful to remind RN CM to update svc plan & bios. Any discrepancies will be brought to the attention of RN CM & Health care provider assigned to each clients.

Sincerely

Hedden S. Anderson  
99-322 Ave ave St  
Area #1 96701

PH

attn:

Operations Manager  
CTA

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How to prevent the deficiency from happening with other Clients record?

Caregiver (Hemdin) will be aware of all individual Client's records. It is our responsibility to fully know & aware the services planned for each Client. If we are not sure always check the Client's SUC plan to clarify what we are suppose to do. Classified orders should be given full attention because this case has ~~more~~ the clients like & safety.

01/11/2017 05:50

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How to prevent the discrepancy from happening with other Client's record?

Caregiver (Nurse) will be aware of all individual Client's records. It is our responsibility to fully know & aware the services planned for each Client. If we are not sure always check the Client's SUC plan to clarify what we are suppose to do. Classified orders should be given full attention because this case lies under the Client's life & safety.

Substitute caregivers are trained to be alert & aware to a given situation. Be familiar for information & instructions on how to care & safety our clients. We should always be aware what belongs to our clients. We should coordinate w/ the RN CM & health care provider implementing the Service Plan. We should be fully knowledgeable what the Service Plan content.

The house has now a tracking log for due dates. Caregiver (Nurse) will always be tactful to remind R.N. CM. to update SUC Plan & b.mos. Any discrepancies will be brought to the attention of R.N. CM & Health care provider assigned to each Client's.

Sincerely  
 Helina S. Aguilar  
 99-322 Alhambra St  
 Area #1 96701  
 PH

attn:  
 Operations Manager  
 CTA

Rec'd 2/16/17

2/14/17

CJA

45-955 Kam Hwy, Ste 300

Kaneohe, HI 96744

Re: Written Plan of Correction

Records (17-1454-52)

52.C.2 - SVC plan for client #2 is dated 5/17/16 over 6 months  
and no representative signature. [REDACTED]

[REDACTED], daughter, signed on 2/12/17.

RN, case manager, Gail Smith, SVC plan for  
Client #2 for 11/18/16 was filed on client #2  
Record.

[REDACTED], the daughter representative,  
will come + sign on her visit + her mother.

DR [REDACTED] will also sign on her next  
visit + appt.

⊗ SVC plan says no CPR, Polst + face sheet  
says no CPR. Client #2 SVC Plan, was  
corrected by RN CMA regarding DNR  
according to Polst. This will not happen  
again because this document will  
remain in the <sup>Client</sup> chart + will remind  
the CMA to update.

# "Coat"

52.C.5

## \* 3 medication discrepancies for Client #2

### 1) Tylenol 500 mg

Primary caregiver (Hedidia) was able to find Tylenol of 325 mg + will always focus her attention on what was prescribed for the Client.

### 2) ~~Vit B-12~~

Vit B-12

- 250 mcg

RD, CM Gail Smith corrected the Vit B-12 to 2500 mcg will reflect on the next month MAR.

### 3) Resperdone 2mg ODT

1-Tab 2mg ODT Bid was corrected by RD, CM, Gail Smith: It will reflect on next month MAR.

(Ph see attached)

(Cont)

Comments:

How you can prevent the discrepancies from happening with other clients records?

- ⊗ Caregiver (Hedira) will double check all orders, make sure prescription from pharmacy was the medication prescribed by health care provider, always be familiar w/ medication + w/c medications belong to the client. If not familiar ask the pharmacy if it is a generic brand.
- \* Any discrepancies will be brought thru the attention of the RN, + health provider assigned to the client. Caregiver will be extra careful handling these medications.

Sincerely

Hedira S. Aguilar

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