Foster Family Home - Criteria Report

Provider ID: 1-170066

Home Name: Lenie Flores ,CNA

91-820 Lakana Place

Ewa Beach, HI 96706

Review ID:

Reviewer: Carrie Wakai

Begin Date: 11/24/2017 End Date: 11/27/2017

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

☑	6.(b)	Any person, agency, or organization that wants to operate a home as a community care foster family home to provide, for a fee, twenty-four-hour living accommodations, including personal care and homemaker services for adults who have nursing facility level of care needs and are not related to the person providing the care, shall obtain a certificate of approval from the department.
	6.(d)	To be certified as a community care foster family home, a person, agency, or organization shall:
☐	6.(d)(1)	Comply with all applicable requirements in this chapter; and
☑	6.(d)(2)	Not have had a previous license or certificate to provide social or health care services that was revoked within twelve months of the current application for a certificate of approval, except that this restriction shall not apply if the revocation was successfully appealed.

Comment: 6.d.1 Home visit made for a new 2 person certification survey. Corrective action report was issued during the visit with a corrective action plan due to CTA by 12/08/17.

The Primary Caregiver shall meet the following requirements:

41(b)(8)-Have documentation of current training in blood borne pathogen and infection control, cardiopulmonary resuscitation and basic first aid.
Comment:
41.b.8- No documentation of blood borne pathogen training present for CG#1.

Carrie Wakai RN — 11/24/17

Compliance Manager — Date

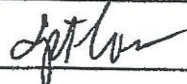
[signature] — 11/24/17

Primary Care Giver — Date

Community Care Foster Family Home (CCFFH)
Written Plan of Correction for Deficiencies
Listed in Corrective Action Report
Chapter 17-1454

CCFFH Name:
CCFFH Address:

Rule Number	Corrective Action Taken	Date Corrected	Prevention Strategy
41 b8	Caregiver #1 obtain the bloodborne pathogens & placed it in the home records	11/26/17	I will make a chart for my substitute caregivers with due date bloodborne pathogens requirements & I will place it infront of my binder

Primary Caregiver's Signature: 

Print Name: Lenie P. Flores Date of Signature: 11/27/17