

Foster Family Home - Corrective Action Report

Provider ID: 1-100035

Home Name: Mitci C. Aguinaldo, NA

Review ID: 1-100035-6

1297 Kukila St.

Reviewer: David Ayling

Honolulu HI 96818

Begin Date: 1/30/2018

End Date: 3/1/18

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 3 person CCFFH recertification review made on 1/30/18. Corrective Action Report issued during home visit with all items due to CTA by 2/1/18.


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

3 Person Staffing 3 Person Staffing Requirements [17-1454-41] (3P)

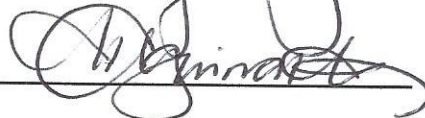
41.(3P)(a)(4) A current Certified Nurses Aide or Nurse Aide certificate plus one year of experience in a home setting. If the certificate is expiring within the next 30 days, evidence of a new certificate must be provided. Substitute caregivers have a minimum of one year work experience as a caregiver in a community residential setting or in a medical facility.

Comment:

41.(3P)(a)(4) - CG #1 is not a Certified Nurses Aide.


Compliance Manager

Date


Primary Care Giver

Date

1/30/18

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

CCFFH Name: MITCI C. AGUINALDO

CCFFH Address: 1297 KUKILA STREET, HONOLULU, HAWAII 96818

Rule Number	Corrective Action Taken	Date Corrected	Prevention Strategy
41.(3P) (a)(4)	I have transferred one client out of my CCFFH. Decreased to 2-client bed CCFFH.	03/01/2018	I will be decreasing from 3-client bed to 2-client bed CCFFH in the meantime.

Primary Caregiver's Signature:  _____

Print Name: MITCI AGUINALDO

Date of Signature: 03/01/2018