

# Foster Family Home - Corrective Action Report

Provider ID: 1-616279

Home Name: Ligaya Bercasio, RN

Review ID: 1-616279-5

94-500 Alapine Street

Reviewer: Jackie Chamberlain

Waipahu HI 96797

Begin Date: 2/16/2021

## Foster Family Home Required Certificate [11-800-6]

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

Comment:

6(d)(1) CCFFH inspection made for a 3 bed re-certification inspection.  
Corrective action report issued during CCFFH visit with corrective action plan due to CTA within 30 days of inspection.

## Foster Family Home Personnel and Staffing [11-800-41]

41.(b)(6) Comply with all applicable federal, state, and county laws, ordinances, rules, regulations, and regulatory requirements, including but not limited to statutes that prohibit discrimination against any person, on the grounds of race, color, national origin, religion, creed, sex, age, marital status, or handicap;

Comment:

41.(b)(6) Per DPP website, the home has 3 bedrooms, but physical count of bedroom is 6 bedroom The structure of the home does not meet this description. Possibly additions have been made without a building permit. Due to pandemic and possible State and County closures CCFFH will have 1 year to reconcile with DPP

## Foster Family Home Medication and Nutrition [11-800-47]

47.(d)(1) By order of a physician;

Comment:

47.(d)(1) There is no MD signed orders for client # 1 or # 2

## Foster Family Home Physical Environment [11-800-49]

49.(a)(4) Wheelchair accessibility to sleeping rooms, bathrooms, common areas and exits, as appropriate;

Comment:

49.(a)(4) there is a lock on a sliding door between the clients bedrooms and the rest of the home locking the clients into a section of the home without a kitchen, recreational room or eating space

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Foster Family Home

Records

[11-800-54]


54.(c)(3) Current copies of the client's physician's orders;


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

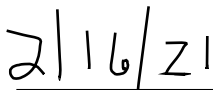
Comment:


54.(c)(3) None for client 1 or 2

54.(c)(5) Medication discrepancy for client # 2 medication prescription label did not match medication administration record and / or the signed MD orders. CMA RN to determine if a medication error has occurred

  
\_\_\_\_\_  
Compliance Manager

  
\_\_\_\_\_  
Primary Care Giver

  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Date