Foster Family Home - Corrective Action Report

Provider ID:	**4-624628**		
Home Name:	**Era Luczon, CNA**	**Review ID:**	**4-624628-8**
97 Hoku Puhipaka Street		Reviewer:	Terri Van Houten
Kahului HI 96732		Begin Date:	5/3/2021

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

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

Comment:

6.(d)(1) - Unannounced home inspection for 2 bed CCFFH recertification. Report issued during home inspection with written plan of correction due to CTA by 6/3/2021.

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

41.(b)(7) Have a current tuberculosis clearance that meets department guidelines; and

Comment:

41.(b)(7) - CG#1 and CG#3 did not have a current TB clearance.

41.(b)(8)- CG#1, CG#3 and CG#4 did not have evidence of BBP/Infection control training within the last year.

Foster Family Home	**Fire Safety**	**[11-800-46]**

46.(a) The home shall conduct, document, and maintain a record, in the home, of unannounced fire drills at different times of the day, evening, and night. Fire drills shall be conducted at least monthly under varied conditions and shall include the testing of smoke detectors.

Comment:

46.(a) - CCFFH did not have evidence of monthly fire drills conducted. Last documented fire drill was from June 2020.

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

47.(c) Medication errors and drug side effects shall be reported immediately to the client's physician, and the case management agency shall be notified within twenty-four hours of such occurrences, as required under section 11-800-50(b). The caregivers shall document these events and the action taken in the client's progress notes.

Comment:

47.(c) - Client #1 did not have list of medication side effects present in their records.

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Foster Family Home	**Records**	**[11-800-54]**

54.(b)	The home shall maintain separate notebooks for each client in a manner that ensures legibility, order, and timely signing and dating of each entry in black ink. Each client notebook shall be a permanent record and shall be kept in detail to:
54.(c)(2)	Client's current individual service plan, and when appropriate, a transportation plan approved by the department;
54.(c)(3)	Current copies of the client's physician's orders;
54.(c)(5)	Medication schedule checklist;
54.(c)(6)	Daily documentation of the provision of services through personal care or skilled nursing daily check list, RN and social worker monitoring flow sheets, client observation sheets, and significant events that may impact the life, health, safety, or welfare of, or the provision of services to the client, including but not limited to adverse events;
54.(c)(8)	Personal inventory.

Comment:

54.(b) - Client #1 did not have any caregiver progress notes documented since admission.

54.(c)(2) - Client #1 did not have a recent review of the service plan, last from 9/30/20.

54.(c)(3) - Client #1 did not have copies of MD orders.

54.(c)(5) - Client #1 did not have a MAR started for May, last documented medication administered 4/28/21.

54.(c)(6) - Client #1 did not have a ADL flow sheet started from May.
RN Progress notes missing from March 2021.

54.(c)(8) - Client # 1 did not have a copy of the personal inventory record from admission.

Compliance Manager — Date: 5/3/21

Primary Care Giver — Date: 5/3/21