

# Foster Family Home - Deficiency Report

Provider ID: 3-626070

Home Name: Almira Acasio, CNA

Review ID: 3-626070-13

76-6183 Holualoa Beach  
Road

Reviewer: Terri Van Houten

Kailua-Kona HI 96740

Begin Date: 7/27/2021

## 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 annual home inspection for 3 bed CCFFH. Report issued during home inspection with written plan of correction due to CTA by 8/27/2021.

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

41.(b)(4) Cooperate with the department to complete a psychosocial assessment of the caregiving family system in accordance with section 11-800-7.(b)(2).

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

Comment:

41.(b)(4) - CCFFH is missing page 1 of the primary care disclosure form.

41.(b)(7) - TB clearance documents for CG#1, CG#2 and HHM#2 have appear to have been altered or have white out over the dates and names of CG for the last 3 years.

## Foster Family Home Client Care and Services [11-800-43]

43.(c)(3) Be based on the caregiver following a service plan for addressing the client's needs. The RN case manager may delegate client care and services as provided in chapter 16-89-100.

Comment:

43.(c)(3) - CG#2 and #3 did not sign the RN delegations for Client #3.

## 3 Person Fire Safety, Natural Disaster 3 Person Fire Safety (3P) Fire

(3P)(b)(6) Fire shall include all SCGs at least once per year

Comment:

(3P)(b)(6) Fire - CCFFH did not have evidence that CG#2 has conducted a fire drill in the last 12 months.

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

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

Comment:

47.(d)(1) - Client #3 did not have a current [REDACTED] admission orders.

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Foster Family Home


Records

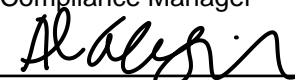
[11-800-54]

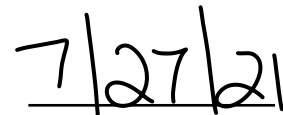
54.(c)(5) Medication schedule checklist;


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Comment:

54.(c)(5) - Client #2 MAR/MD Order did not match the label on the prescription bottle. Bottle of medication appears to have expired in 2/2021.

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

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

  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Date