Foster Family Home - Deficiency Report

Provider ID: 5-190079

Home Name: Lielany Defontorum, CNA
4369 Anai Street
Lihue HI 96766

Review ID: 5-190079-5
Reviewer: Maribel Nakamine
Begin Date: 7/21/2021

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

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

Comment:

Unannounced annual inspection for a 2 person CCFFH completed.

Deficiency Report issued during CCFFH inspection with a written plan of correction due to CTA on 8/21/2021.

Foster Family Home — Background Checks [11-800-8]

8.(a)(1) Be subject to criminal history record checks in accordance with section 846-2.7, HRS;

8.(a)(2) Be subject to adult protective service perpetrator checks if the individual has direct contact with a client; and

Comment:

8.(a)(1), (2)- CG#3's APS/CAN/Fingerprinting lapsed on 7/13/2021 and no current renewal result present in the CCFFH binder.

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#3's TB clearance lapsed on 6/12/2021 and no current renewal result present in the CCFFH binder.

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

46.(b)(2) All caregivers have been trained to implement appropriate emergency procedures in the event of a fire.

Comment:

46.(b)(2)- CG#2, CG#3, and CG#4 were without evidence of conducting a monthly fire drill for the past 12 months.

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

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

49.(b)(3) Be in close proximity to the primary or substitute caregiver for timely intervention for nighttime needs or emergencies, or be equipped with a call bell, intercom, or monitoring device approved by the case management agency.

Comment:

49.(a)(4)- Front door of the CCFFH was obstructed with a large exercise machine and a lounge chair preventing a clear pathway for a wheelchair to pass through safely in the event of an emergency.
49.(b)(3)- CG#1's bedroom location was noted to be far from the clients' bedrooms. No monitoring device/call system present in each client's bedroom for clients' use.

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Foster Family Home **Quality Assurance** **[11-800-50]**

50.(a) The home shall have documented internal emergency management policies and procedures for emergency situations that may affect the client, such as but not limited to:

Comment:

50.(a)- CG#2, CG#3, and CG#4 were without evidence of having had the CCFFH's Emergency Preparedness Plan training.

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

54.(c)(2) Client's current individual service plan, and when appropriate, a transportation plan approved by the department;

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

Comment:

54.(c)(2)- Client #2's Service Plan only had 1 page present out of 8 pages in the client's binder. Incomplete Service Plan.
54.(c)(5)- Medication discrepancy noted for Client #1. One medication's label didn't match the MD order and the Medication Administration Record (MAR).

Maribel Nakamie, W 7/21/2021
Compliance Manager Date

[illegible] 7/21/2021
Primary Care Giver Date

7/21/2021 2:08:23 PM

CTA RN Compliance Manager: Maribel Nakamine

Community Care Foster Family Home (CCFFH)
Written Corrective Action Plan (CAP)
Chapter 11-600

PCG's Name on CCFFH Certificate: Lielany Defontorum
(PLEASE PRINT)

CCFFH Address: 4369 Anai Street, Lihue Hi. 96766
(PLEASE PRINT)

Rule Number	Corrective Action Taken – How was each issue fixed for each violation?	Date each violation was fixed	Prevention Strategy – How will you prevent each violation from happening again in the future?
49.(b)(3)	CG #1 obtained and bought a monitoring device for clients use.	7/30/21	Home has installed a video monitor, alarm + callbell to ensure clients safety. to monitor them well. to respond + help them faster.
50. (a)	CG #2, CG #3, CG #4 was trained on Emergency Preparedness plan and signed the form. Forms has been put into the CCFFH binder	7/23/21	In the future, all SCG will receive this training w/in 7-10 days of being added to the home.
54.(c)(2)	client #2 Service Plan complete + filed in clients binder.	8/7/21	- Home will check + make sure all documents needed are present upon admission
54.(c)(5)	Medication discrepancy was corrected by clients CMA, MD and CG #1 on clients medication Administrative Record.	7/30/21	CG #1 will look all medication order, bottles + MAR to ensure all match before signing any new orders medication. Home will notify CMA pharmacy + doctor if they are different.

☑ All items that were fixed are attached to this CAP

PCG's Signature: LDefontorum Date: 8/18/21

☑ CTA has reviewed all corrected items