

# Foster Family Home - Deficiency Report

Provider ID: 1-220084

Home Name: Amy Quindara, CNA

Review ID: 1-220084-3

2312-A Kalihi Street

Reviewer: Po Lim

Honolulu

HI 96819

Begin Date: 7/6/2023

## 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 visit made for a 2 bed re-certification inspection.

Deficiency Report issued during CCFFH inspection via email on 7/6/2023 with Plan of Correction due to CTA within 30 days of inspection date of issuance.

## 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).

Comment:

41.b.4 No disclosure form present for CG#3 and CG#4.

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

47.(a) A licensed practical nurse or a registered nurse shall administer medications that are to be injected, unless physician orders permit a client to self-inject. The registered nurse may delegate the administration of medication as provided in chapter 16-89, section 16-89-100.

Comment:

47.a No RN delegation present for CG#2, 3, 4 for client # 1 medication administration. No RN delegation present for CG#4 for client #2 medication administration.

## 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) - The CCFFH did not have evidence that a documented internal emergency management policy and procedure was in place. CG#3 and #4 did not receive the EPP training.

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Foster Family Home


Insurance Requirements

[11-800-51]

51.(a)(1) General;

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Comment:

51.(a)(1) - The CCFFH did not have evidence that all CGs are included on the liability insurance policy. CG# 3 and #4 is not included on the policy.

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

  
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Primary Care Giver

  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Date