

# Foster Family Home - Deficiency Report

Provider ID: 4-110011

Home Name: Adela Suzuki, NA

Review ID: 4-110011-14

607 South Kamehameha  
Avenue

Reviewer: Terri Van Houten

Kahului HI 96732

Begin Date: 11/21/2023

## 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 annual inspection for 2 bed CCFFH. Report issued during CCFFH inspection with written plan of correction due to CTA by 12/21/23.

42. CCFFH did not have evidence of a form 1147 for client #2.

## 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) - CCFFH did not have evidence of two consecutive sets of fingerprints for CG#6 and CG#7. CG#6's FP was due on or before 10/26/23. CG#7 was due on or before 11/2/23.

8.(a)(2) - CCFFH did not have evidence of two consecutive sets of APS/CAN reports for CG#6 and CG#7. CG#6's APS/CAN was due on or before 10/26/23. CG#7 was due on or before 11/2/23.

## 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#6 and CG#7 did not have evidence that RN delegation was provided for client #1.

## 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#6 and CG#7 did not have evidence of conducting a fire drill within the last 12 months.

# Foster Family Home - Deficiency Report

Foster Family Home

Records

[11-800-54]

54.(c)(1) Client's vital information;

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

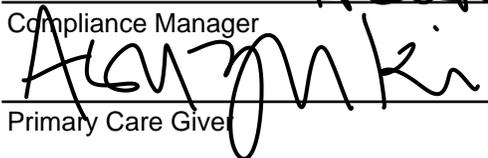
54.(c)(5) Medication schedule checklist;

Comment:

54.(c)(1) - CCFFH did not have a face sheet for client #2.

54.(c)(2) - CCFFH did not have evidence of a service plan for client #1. Client admitted on 11/17/23.

54.(c)(5) - Medication discrepancy noted for client #2. Dose is different between the order, MAR, and the prescription label.

  
\_\_\_\_\_  
Compliance Manager  
  
\_\_\_\_\_  
Primary Care Giver

11/21/23  
\_\_\_\_\_  
Date  
11/21/23  
\_\_\_\_\_  
Date