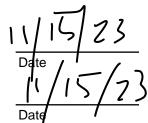
| | | Foster Fami | ly Home - | Deficie | ency Report | | |
|--|--|--|--------------|-------------------------------|--|--|--|
| Provider ID: 1 | -200065 | | | | | | |
| Home Name: R | khea Joy Nabu | ıa, CNA | Review ID: | 1-200065-9 | 9 | | |
| 91-146 Wailohia Pl | ace | | Reviewer: | Ryan Nakai | amua | | |
| Ewa Beach | HI | 96706 | Begin Date: | 11/15/2023 | 3 | | |
| Foster Family H | ome Re | equired Certificate |) | | [11-800-6] | | |
| 6.(d)(1) Comply with all applicable requirements in this chapter; and Comment: | | | | | | | |
| 6.(d)(1) - Unanno written plan of co | unced CCFFI rrection due te | H inspection for 3 b o CTA within 30 day | ed CCFFH rec | ertification. tion (inspec | . Report issued during CCFFH inspection with ction date 11/15/2023). | | |
| Foster Family He | ome In | formation Confide | entiality | | [11-800-16] | | |
| 16.(b)(5) | | ng to all employees, a nd client privacy rights | 5 | | in the home, on their confidentiality policies and | | |
| Comment: | | | | | | | |
| 16.(b)(5): No evidence by CCFFH of CG#5 receiving confidentiality training by CCFFH. No documentation presented by CCFFH. | | | | | | | |
| Foster Family He | ome Pe | ersonnel and Staff | ing | | [11-800-41] | | |
| 41.(b)(4) | | th the department to c /ith section 11-800-7.(| (b)(2). | | sessment of the caregiving family system in | | |
| Comment: | | | | | | | |
| 41.(b)(4): No documentation provided by CCFFH that CG#5 completed disclosure form for CCFFH. No documentation provided by CCFFH. | | | | | | | |
| Foster Family He | ome Me | edication and Nuti | rition | | [11-800-47] | | |
| 47.(d)(1) | By order of a | physician; | | | | | |
| Comment: | | | | | | | |
| 47.(d)(1): No evidence by CCFFH of MD order for bed side rails to be used for client #1. No documentation provided by CCFFH. | | | | | | | |
| Foster Family H | ome Re | ecords | | | [11-800-54] | | |
| 54.(c)(5) | Medication sc | hedule 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; | | | | | | |
| Comment: | | | | | | | |
| 54.(c)(5): No evidence of medication being administered for client #1 and client #2 since 11/07/2023. No documentation noted in MAR. | | | | | | | |
| | | H are blank since 1 | | heets have | e been documented since 11/07/2023. $ \underbrace{11/15/23}_{\text{Date}} $ | | |

| & M | |
|--------------------|--|
| Compliance Manager | |
| Primary Care Giver | |



11/15/2023 11:24:37 AM