

Foster Family Home - Deficiency Report

Provider ID: 1-511510

Home Name: Adelaide Pascual, CNA

Review ID: 1-511510-17

99-446 Hakina Street

Reviewer: Ryan Nakamua

Aiea HI 96701

Begin Date: 3/18/2024

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 CCFFH inspection for 3 bed CCFFH recertification. Report issued during CCFFH inspection with written plan of correction due to CTA within 30 days of inspection (inspection date: 3/25/2024).

6.(d)(1): No documents provided of current 1147 assessments for client #2 and client #3.

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

41.(g) The primary and substitute caregivers shall be assessed by the department for competency in basic caregiver skills and specific skill areas needed to perform tasks necessary to carrying out each client's service plan. The documentation of training and skill competency of all caregivers shall be kept in the client's, case manager's, and caregiver's current records with the current service plan.

Comment:

41.(g): No documentation provided by CCFFH of basic caregiver skills checked for client #1 for all caregivers.

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): No documentation of RN delegation from client #1's case management agency for all caregivers.

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

49.(a)(6) A means of unobstructed travel from the client's bedroom to the outside of the dwelling at street or ground level.

Comment:

49.(a)(6): Obstructed hallway with boxes and other personal belongings that is included CCFFH's evacuation map.

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Records

[11-800-54]

- 54.(b) The home shall maintain separate notebooks for each client in a manner that ensures legibility, order, and timely signing and dating of each entry in black ink. Each client notebook shall be a permanent record and shall be kept in detail to:
- 54.(b)(1) Permit effective professional review by the case management agency, and the department; and
- 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;
- 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:

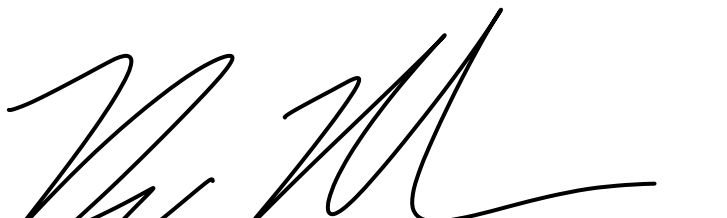
54.(b): No evidence by CCFFH of current no entries of progress notes regarding events or changes within the last 12 months for client #1, client #2, and client #3.

54.(b)(1): All client binders in disarray and CCFFH unable to provide documents requested in timely manner.


54.(c)(2): No evidence by CCFFH of service plan conducted every six months for client #2. No documentation of a service plan dated 5/2023 was provided by CCFFH.

54.(c)(5): Evidence of medication discrepancy regarding one medication's order related to client #2's medication administrative record. According to physician order, Medication to be given as needed if according to blood pressure parameter. In MAR, medication is ordered to be given routine with no parameter stated.


54.(c)(6): No evidence by CCFFH of documentation daily flowsheets and vital signs documented for all clients. No documentation for client #1 since client's admission 2/23/2024; no documentation for client #2 of vital signs since 12/31/2023; no documentation of vital signs for client #3 since 2/2024 and flow sheets since 1/30/2024.



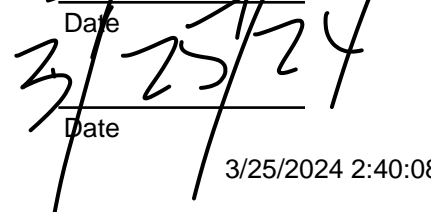
Compliance Manager



Primary Care Giver



Date



Date