

Foster Family Home - Deficiency Report

Provider ID: 4-150015

Home Name: Xzor Jay M. Daguio, CNA

Review ID: 4-150015-14

3 Puualoha Place

Reviewer: Terri Van Houten

Kahului HI 96732

Begin Date: 4/10/2024

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 issuance.

42. - The CCFFH did not have evidence of a current 1147 completed for client #1.

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) - The CCFFH did not have evidence that CG#3 and CG#5 had completed the basic skills check for client #1.

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) - The CCFFH did not have evidence that RN delegations had been provided for CG#3 for client #1.

43.(c)(3) - The RN delegations for client #2 did not include the date of completion for CG#3, CG#5 or for the RN who provided the delegations to any of the caregivers.

Foster Family Home Client Transfer/Discharge [11-800-44]

44.(e)(2) Providing access to the client's file during relocation and return of the file to the case management agency upon relocation

Comment:

44.(e)(2) - Client #2 had been transferred into the CCFFH on 1/5/24. Client #2's chart from the previous CCFFH had been left with the client in their current location.

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Medication and Nutrition

[11-800-47]

- 47.(b) The caregivers shall obtain training, relevant information, and regular monitoring from the client's physician, a home health agency, as defined in chapter 11-97, or a Registered nurse for all medication that the client requires.
- 47.(c) Medication errors and drug side effects shall be reported immediately to the client's physician, and the case management agency shall be notified within twenty-four hours of such occurrences, as required under section 11-800-50(b). The caregivers shall document these events and the action taken in the client's progress notes.

Comment:

47.(b) - The CCFFH did not have evidence that the medications were regularly being monitored by the MD, Home Health or CMA RN for client #1 and client #2. Client #1's MAR did not include an RN signature indicating a review of the document for January 2024, February 2024 and March 2024. Client #2's MAR did not include an RN signature indicating a review of the document for February 2024 and March 2024.

47.(c) - The CCFFH did not have evidence of a list of medication side effects for client #1.

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Client Account

[11-800-48]

- 48.(a) The home shall maintain a written accounting of the client's personal funds received and expended on the client's behalf by the home.

Comment:

48.(a) - The CCFFH did not have evidence of who was identified to manage the personal needs allowance for client 2.

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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)(3) Current copies of the client's physician's orders;
- 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;
- 54.(c)(8) Personal inventory.

Comment:

54.(c)(2) - The CCFFH did not have evidence that the service plan had been reviewed and signed by the client/POA for client #1.

54.(c)(3) - The CCFFH did not have copies of physician orders for client #2 who was transferred into the CCFFH on 1/5/24.

54.(c)(5) - The CCFFH did not have evidence that the MAR matched the current MD orders and prescription bottles for client #1 and client #2.

Client #1 - Most recent instructions for Eliquis indicated dose to be given daily effective 4/7/24. MAR and Prescription bottle indicated it was to be given twice daily. Dose was administered twice daily on 4/8/24. Prescription bottle of Diltiazem includes the comment "for 30 days", but MAR reflects the medication is to be administered daily with no stop date.

Client #2 - Prescription for Senna is present with the client's medications but it is not included on the MAR from January through April 10, 2024. Medication was last charted as given on January 4, 2024 prior to transfer into the current CCFFH.

54.(c)(6) - The CCFFH did not have evidence that the ADL flow sheets were being monitored and reviewed monthly by the CM RN. No RN signature was present on the documentation for client #1 or client #2 for January 2024, February 2024 and March 2024.

54.(c)(6) - The CCFFH did not have evidence that an RN monthly visit was conducted in February 2024 for client #2.

54.(c)(8) - The CCFFH did not have evidence of a personal inventory list being completed upon transfer in for client #2.

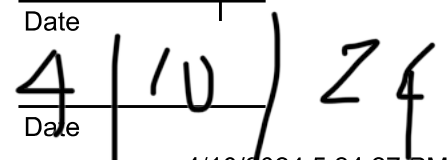


Compliance Manager

Primary Care Giver



Date



Date

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