Foster Family Home - Deficiency Report

Provider ID:	**4-622284**		
Home Name:	**Marjory Bumatay, CNA**	**Review ID:**	**4-622284-23**
448-A N. Wakea Avenue		Reviewer:	Terri Van Houten
Kahului HI 96732		Begin Date:	4/11/2024

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 visit made for a 3 bed CCFFH to investigate a compliant received by CTA on 2/2/2024.

The complaint has been substantiated and additional deficiencies found unrelated to complaint.

Deficiency report issued via certified mail on 05/01/2024 with written plan of correction due to CTA within 30 days of issuance.

Foster Family Home — Information Confidentiality — [11-800-16]

16.(a) All information relating to individuals who apply for or receive home and community-based case management and community care foster family home services shall be confidential.

16.(b)(3) Inform clients about their confidentiality practices;

Comment:

16.(b)(3), - The CCFFH did not have evidence that the facility's written policy and procedure concerning client confidentiality had been reviewed with and provided to a previous client/POA (OPG), 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.

41.(j)(2) Assure that a substitute caregiver is available and capable of managing all client care and any event occurring in the home; and

Comment:

41.(g) - CG#1 confirmed that she was on vacation and away from the CCFFH from 1/22/24 through 1/30/24. During that time, CG#1 stated that an SCG (referred to as CG#2) remained at the CCFFH with three clients, 24/7, the entire time that CG#1 was on vacation. CG#1 stated that CG#2 did not have a basic skills check completed by the CMA RN prior to assuming oversight for the three clients present in the CCFFH. CG#1 stated that she had used a blank basic skills check form that was left in her client binder which had previously been signed by the CMA RN. The pre-signed form is what CG#1 provided to CG#2 for a signature on 1/22/24.

41(j)(2) CG#2 provided cae 24/7 from 1/22/24 to 1/30/24. There was no documentation in the client or CCFFH record to indicate CG#2 received all necessary training and RN delegation to adequately manage all client care.

No documentation was completed by CG#2 for any client care.

3 Person Staffing	3 Person Staffing Requirements	(3P) Staff

(3P)(b)(2) Staff	Allowing the primary caregiver to be absent from the CCFFH for no more than twenty-eight hours in a calendar week, not exceed five hours per day; provided that the substitute caregiver is present in the CCFFH during the primary caregiver's absence. Where the primary caregiver is absent from the CCFFH in excess of the hours, the substitute caregiver is mandated to be a Certified Nurse Aide, per 321-483(b)(4)(C)(D) HRS.

Comment:

(3P)(b)(2) Staff (HRS 321-483(b)(4)(C-D) - The CCFFH did not have evidence that a 3 client sign out log had been maintained since April 2023. These records are supposed to be maintained anytime the primary caregiver is outside of the CCFFH including next door at the other CCFFH on the property.

CG#1 confirmed that she was out of town on vacation between 1/22/24 through 1/30/24, and no 3 client sign out log was maintained during this time. CTA was unable to confirm that the CCFFH had adequate coverage for three clients during that time. CTA was told that CG#2 (a nurse aide) provided 24/7 care from 1/22/24 to 1/30/24 (9 consecutive days) for all 3 clients for more than the allowed 5 hrs/day up to the allowed 28 hrs/week.

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.
43.(c)(4)	Include the provision of personal care, homemaker, and respite services as appropriate;

Comment:

43.(c)(3) - The service plan for client #1 stated a two-person assist was needed to provide all client care. Evidence shows the CCFFH had been approved to receive a higher rate to allow for the provision of two-person assist and CG#1 was made aware of the need for a two person assist for all ADLs prior to admission on 12/1/23. CG#1 did not consistently provide two caregivers as identified in the service plan. CG#1 stated during an interview she was not made aware that two people were needed. However, there is documented evidence to the contrary and the CCFFH was being paid a higher rate to accommodate for two people by the client's health plan.

43.(c)(4) - CCFFH did not provide client services at the frequency identified in the service plan. The service plan for client #1 indicated that the client should receive a daily bath or shower. CCFFH ADL flowsheet documents showed that the client was bathed every 4 - 5 days. The documentation did not include any client's refusal to be bathed in the month of January and only two documented refusals in the month of December.

The client was initially provided a shower in December 2023, and this was changed to a bed bath to a partial bed bath in January 2024. The inability to provide daily bathing and the decline in the client's condition was not documented as reported to the client's CMA.

CCFFH failed to provide client #1 with dietary supplement (prune juice daily) as directed in the service plan per interview with CG#1 stating it was not given.

Foster Family Home - Deficiency Report

Foster Family Home	**Grievance**	**[11-800-45]**

45.	The community care foster family home shall have policies and procedures by and through which a client may present grievances about the operation or services of the home. The policies shall include a provision that a client may choose to present any grievance directly to the department of health. The home shall:
45.(1)	Inform the client or the client's legal representative of the grievance policies and procedures and the right to appeal in a grievance situation;
45.(2)	Provide a written copy of the grievance policies and procedures to the client or the client's legal representative, which includes the names and telephone numbers of the individuals who shall be contacted in order to report a grievance; and
45.(3)	Obtain signed acknowledgements from the client or the client's legal representative that the grievance policies and procedures were reviewed

Comment:

45.(1-3) - The CCFFH did not have evidence that a copy of the grievance policy and procedure was reviewed and received by the client/POA (OPG).

Foster Family Home - Deficiency Report

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.
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.(e)	The caregivers shall obtain specific instructions and training regarding special feeding needs of clients from a person who is registered, certified, or licensed to provide such instructions and training.

Comment:

47.(a) - CG#1 was delegated by a RN case manager to provide administration of medication including reporting any changes to Client #1's CMA.

The CCFFH did not have evidence that prescribed medication orders were followed for client #1. [redacted] as ordered per hospital discharge on 12/1/23. The December 2023 MAR was written on by CG#1 and stated "No order" for [redacted] was not included on the January MAR, and no order was present to discontinue [redacted] CG#1 did not sign for wound ointment ([redacted]) application in January 2024 stating she never received the [redacted]. Ointment administration was ordered to be applied twice daily per hospital discharge orders on 12/1/23. [redacted] was signed for twice daily in the month of December 2023 by CG#1.

47.(a) - CG#1 implemented care and services for client #1 which had not been ordered by a PCP, and for which there was no RN delegation. CG#1 indicated in the progress notes that Vaseline and an ointment (unknown what kind and referred to by CG#1 during an interview as a "home remedy") was applied to client #1's skin. CG#1 indicated that these ointments were present in the CCFFH from past clients and therefore giving a medication prescribed for previous clients to Client #1. CG#1 could be considered practicing medicine without a license and exceeding her scope as a CNA by giving over the counter medication, herbal supplements or medication not prescribed by client's doctor to the client. Use of "home remedies" are not allowed in CCFFH as all treatments and medications must be ordered by a physician or nurse practitioner.

47.(a). - CG#1 confirmed the use of a "peter pocket" for client #1 to manage urinary incontinence. The CCFFH did not have a doctor order nor any instruction/training on the use of a "peter pocket". During the investigation, CTA was not provided with any documentation or evidence to show that this was a standard evidence based nursing practice.

47.(b) - The CCFFH did not have evidence that CG#2 had received RN delegations for oral medication administration for client #1. CG#2 was identified by CG#1 as providing all care and services for all clients in the CCFFH between 1/22/24 through 1/30/24. CG#1 is responsible for obtaining all delegations from the client's CMA for all substitute caregivers the CCFFH utilizes.

CG#2 was unaware what medications she was giving to clients as they were pre-prepared by CG#1 in 7 day medication planners. CG#1 has previously been informed by CTA that medication planners cannot be used in the CCFFHs and are not part of any medication administration delegation. Medication bottles are to be used each and every time comparing the bottle to the medication administration record to ensure the right medication, dosage, and frequency are given to the right client by the right route at the right time and is signed for in the medication administration record after giving the medication.

47.(e) - CG#1 implemented a treatment for client #1 which had not been ordered by a PCP, and for which there was no RN delegation and no assessment. CG#1 documented the administration of thickener to client #1'sliquids. No PCP order or instructions for use were present in the chart. Speech Therapy recommendation note stated puree and thin liquids with no date on note. CG#1 is a CNA and is not licensed or certified to perform nursing or medical assessments or prescribe treatments.

Foster Family Home	Quality Assurance	[11-800-50]

50.(b)	Adverse events shall be reported
50.(b)(1)	A verbal report to the case management agency responsible for the client shall be made within twenty-four hours of the occurrence; and
50.(b)(2)	A written report shall be sent to the case management agency within seventy-two hours, excluding weekends and holidays, following the verbal report required under paragraph (1).
50.(c)	The home shall inform the case management agency of any changes occurring in the client's behavior and functioning that may necessitate a change and update of the client's service plan. A verbal report shall be made to the case management agency serving the client within twenty-four hours of the occurrence of any of the following:
50.(c)(1)	Changes in the client's condition requiring emergency treatment;
50.(c)(2)	Hospitalization of the client;

Comment:

50.(b)(1-2) and 50.(c)(1-2) - The CCFFH did not have evidence that the following incidents/changes in client condition were verbally reported to the client #1's CMA or submitted in writing to the client's CMA using an adverse event form:
- 12/5/23 - Blood spot noted in incontinence briefs. (Change in client condition)
- 12/6/23 - Reddened skin in the groin area, for which Vaseline was applied without an order or direction to do so. (Change in client condition)
- 12/13/23 - Thickener added to liquids due to client coughing when swallowing. (Change in client condition - no instruction or order to put thicken liquids)
- 12/15/23 and 12/27/23 - Difficulty changing client's incontinence brief due to client's disruptive behaviors. (Change in client condition)
- 12/23/24 - Client bed not locking properly, which interfered with the ability to provide safe care to the client and lack of documentation concerning what was done to correct the issue. (Broken equipment)
- 1/17/24 - Development of bedsores on client's back. (Change in client condition)
-1/29/24 - Back redness. (change in client condition)
- 2/1/24 - Client transfer to the emergency room with subsequent hospitalization. (EMS involvement, ER and hospitalization)

Foster Family Home	Client Rights	[11-800-53]

53.(a)	Written policies and procedures regarding the rights of the client during the client's stay in the home shall be established and a copy shall be provided to the client, or the client's legal representative, and made available to the public when requested.
53.(b)(3)	Be fully informed, prior to or at the time of admission, and during the client's stay, of services available in or through the home and related charges;

Comment:

53 (a) and 53.(b)(3) - The CCFFH did not have evidence that the CCFFH's client rights and admission agreement/policy had been provided to the client/client's POA (OPG).

Foster Family Home - Deficiency Report

Foster Family Home	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.(b)(2)	Provide information for necessary follow-up care for the client.
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.(d)	All client records and reports are confidential, as provided in section 17-1454-16, and shall not be released without the written consent of the client or the client's legal representative, or the case management agency, as applicable. The case management agency shall be informed of any request for the release of information concerning clients and shall retain a copy of the client's written consent to release information.
54.(e)	When a client leaves a home, all records and reports kept by the home shall be given to the case management agency.

Comment:

54.(b), 54.(b)(1) - CG#1 failed to return the entirety of the record for client #1 within a reasonable amount of time to the CMA. During the inspection, it was noted that CG#1 had kept the original documents for client #1, including caregiver progress notes, Dec/Jan/Feb MAR, Dec/Jan/Feb ADL flowsheets.

54.(b)(2) - CG#1 did not have evidence of documentation indicating that the client had refused a shower on 12/2/23, and did not document the provision of a daily bath/shower per the service plan. CG#1 did not document the daily collection of vital signs, including pulse oximetry for oxygen saturation. The ADL flowsheet showed vital signs were done every 4-5 days and did not include measurement of oxygen saturation.

54.(c)(5) - The CCFFH did not have evidence that the MAR was documented daily from 1/22/24 through 1/30/24. CG#2 was assigned to provide care and services during this time, but CG#2 did not document on the MAR that the medications had been given. Per CG#1, the medications were documented as given upon her return from vacation.

54.(c)(5) - The CCFFH did not have evidence that client #1 was offered 6-7 glasses of water per day nor whether it was refused.

54.(c)(6) - The CCFFH did not have accurate evidence that daily documentation of the provision of services was completed between 1/22/24 through 1/30/24. Per CG#1, CG#2 was present and providing oversight for three clients in the CCFFH during this time. There was no evidence that CG#2 documented on the client's ADL flowsheet, MAR, or caregiver progress notes. Documentation on the ADL flowsheet, MAR and caregiver progress notes was added by CG#1 upon return from vacation.

54(d) and 54(e)- The CCFFH had client records that they kept including original copies of a discharged client's records, and those records were being stored in another CCFFH on the same property. After discharge, a CCFFH has no authority to keep any client records as any HIPAA release would cease upon discharge. No client records, which are all confidential, are to be maintained or stored in any other CCFFH other than the one the client resides in.

Compliance Manager — Date: 5/1/24

Primary Care Giver — Date

Foster Family Home - Deficiency Report

Foster Family Home **Records** **[11-800-54]**

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Compliance Manager

M. B. S.

Primary Care Giver

Date

5/31/24

Date

4/22/2024 9:36:05 AM