

# Foster Family Home - Deficiency Report

Provider ID: 1-613035

Home Name: Thelma Giron, CNA

Review ID: 1-613035-16

94-1039 Lumikula Street

Reviewer: Ryan Nakamura

Waipahu

HI 96797

Begin Date: 10/8/2024

## 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 2 bed CCFFH recertification. Report issued during CCFFH inspection with written plan of correction due to CTA within 30 days of inspection (inspection date: 10/22/2024).

6.(d)(1): No documentation provided by CCFFH of current 1147 assessment for client #1.

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

41.(b)(7) Have a current tuberculosis clearance that meets department guidelines; and

41.(b)(8) Have documentation of current training in blood borne pathogen and infection control, cardiopulmonary resuscitation, and basic first aid.

41.(c) The primary caregiver shall attend twelve hours, and the substitute caregiver shall attend eight hours, of in-service training annually which shall be approved by the department as pertinent to the management and care of clients. The primary caregiver shall maintain documentation of training received by all caregivers, in the caregiver file in the home.

Comment:

41.(b)(7): Evidence of lapse for TB clearance for CG#1 and CG#4. TB clearance was due by 8/11/2024 for CG#1 and completed 10/02/2024. TB clearance was due by 8/14/2024 for CG#4 and completed 10/02/2024.

41.(b)(8): No evidence of current bloodborne pathogen/infection training for CG#1,CG#2, CG#3, and CG#4. Training was due by 6/10/2024.


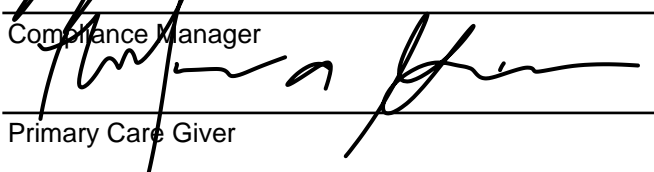
41.(c): No evidence provided by CCFFH of CG#4 training completed minimum 8 hours of annual in-service training in 2023.

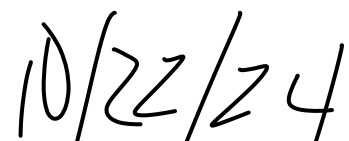
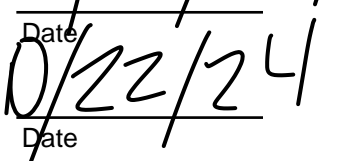
## Foster Family Home Physical Environment [11-800-49]

49.(b)(3) Be in close proximity to the primary or substitute caregiver for timely intervention for nighttime needs or emergencies, or be equipped with a call bell, intercom, or monitoring device approved by the case management agency.

Comment:

49.(b)(3): No evidence provided by CCFFH of written consent/acknowledgement by client/POA of use of camera/monitor in bedroom for client #1.

  
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Compliance Manager  
  
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Primary Care Giver

  
\_\_\_\_\_  
Date  
  
\_\_\_\_\_  
Date