| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COM | | (X3) DATE COMPI 02/17 | LETED | | | | |
|--|---|---|-------|---------------------|--|-----|----------------------------|
| | PROVIDER OR SUPPLIE OME HEALTH CAF | | | 9333 N | MERIDIAN STREET SUITE APOLIS, IN 46260 | 104 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY) | E | (X5) COMPLETION DATE |
| G 000 Bldg. 00 | federal complai Complaint #: I Substantiated: F related to the all | Federal deficiencies legation are cited. | G 0 | 00 | | | |
| | Facility number | : 012680 | | | | | |
| | Surveyor: Debo Health Nurse St | rah Franco, RN, Public urveyor | | | | | |
| | last 12 months: Currer Home Health A Service only Quality Review BSN, RN | licated skilled admissions 285 nt active: 88 Skilled, 28 ide only, 3 Personal : Joyce Elder, MSN, pruary 26, 2015 | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 03/17/2015 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION OF CORRECTION 157645 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 02/17/2015 |
|--|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER PURE HOME HEALTH CARE LLC | | 9333 N | ADDRESS, CITY, STATE, ZIP CODE I MERIDIAN STREET SUITE 10 NAPOLIS, IN 46260 | 4 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| G 134 Bldg. 00 | 484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. Based on review of Indiana Administrative Code 410 IAC 17-14-1 (1)(1)(B), personnel record review, and interview, the agency administrator failed to ensure employees were qualified by confirming the home health aides were registered and in good standing on the state aide registry for 5 of 6 currently employed home health aide (K, L, M, N, O) personnel files reviewed creating the potential to affect all patients who were receiving home health aide services in the agency. Findings include: 1. Indiana Administrative Code 410 IAC 17-14-1 (1)(1)(B) states, "The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the | G 134 | Personnel files are being audi on a daily basis until personne files are current to ensure that of our home health aides are qualified by confirming the hothealth aides are registered and good standing on the state aide registry. All new hires will be confirmed on the state aide registry prior to starting patient care. This is a part of our QAF initiative which began on 1/5/2. The Director of Clinical Servic will be responsible for monitor these corrective actions to ensure that this deficiency is corrected and will not recur, | el t all me d in de t 2015 es ing sure |

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Event ID:

0B4Q11

Facility ID: 012680

If continuation sheet

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| STATEMEN | TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY | |
|-----------|---|------------------------------|--------|------------|---|-----------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BU | JILDING | 00 | COMPL | ETED | |
| | | 157645 | B. W | ING | | 02/17/ | 2/17/2015 | |
| | | | | CTDEET A | ADDRESS, CITY, STATE, ZIP CODE | | | |
| NAME OF P | PROVIDER OR SUPPLIEF | ₹ | | | MERIDIAN STREET SUITE 10 | 4 | | |
| | OME HEALTH CAR | RELIC | | | APOLIS, IN 46260 | 4 | | |
| PURE III | JIVIE HEALTH CAR | AE LLC | | INDIAN | APOLIS, IN 40200 | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE | |
| | • | this section as follows: | | | | | | |
| | (B) be entered or | n and be in good standing | | | | | | |
| | on the state aide | registry." | | | | | | |
| | | | | | | | | |
| | 2. Personnel rec | cord K, a home health | | | | | | |
| | | e 7-25-13 and first patient | | | | | | |
| | • | failed to evidence the | | | | | | |
| | · · | rmined the aide was in | | | | | | |
| | | | | | | | | |
| | | nd on the state registry | | | | | | |
| | prior to providin | g patient care. | | | | | | |
| | | | | | | | | |
| | 3. Personnel rec | cord L, a home health | | | | | | |
| | aide, date of hire | e 3-26-13 and first patient | | | | | | |
| | contact 3-27-13, | failed to evidence the | | | | | | |
| | agency had deter | rmined the aide was in | | | | | | |
| | | nd on the state registry | | | | | | |
| | prior to providin | | | | | | | |
| | prior to providin | ig patient care. | | | | | | |
| | 4 Dargannal rac | cord M, a home health | | | | | | |
| | | - | | | | | | |
| | · · | e 5-12-14 and first patient | | | | | | |
| | | failed to evidence the | | | | | | |
| | | rmined the aide was in | | | | | | |
| | good standing ar | nd on the state registry | | | | | | |
| | prior to providin | g patient care. | | | | | | |
| | | | | | | | | |
| | 5. Personnel rec | cord N, a home health | | | | | | |
| | | e 11-21-13 and first | | | | | | |
| | • | 1-23-13, failed to | | | | | | |
| | - | ency had determined the | | | | | | |
| | | • | | | | | | |
| | _ | d standing and on the | | | | | | |
| | state registry pri | or to providing patient | | | | | | |
| | care. | | | | | | | |
| | | | | | | | | |
| | 6. Personnel rec | cord O, a home health | | | | | | |

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Event ID:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ſ ′ | ULTIPLE CO | NSTRUCTION 00 | (X3) DATE | | | |
|--|---------------------|---|------------|------------------|--|----|-------------------------|--|
| AND FLAN | OF CORRECTION | 157645 | | | | | COMPLETED 02/17/2015 | |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | | |
| NAME OF P | ROVIDER OR SUPPLIEF | 8 | | | MERIDIAN STREET SUITE 104 | 4 | | |
| PURE HOME HEALTH CARE LLC | | | INDIAN | APOLIS, IN 46260 | | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX TAG | * | ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION DATE | |
| 1710 | | e 7-14-14 and first patient | | mo | · | | DATE | |
| | - | failed to evidence the | | | | | | |
| | | rmined the aide was in | | | | | | |
| | | nd on the state registry | | | | | | |
| | prior to providin | g patient care. | | | | | | |
| | | | | | | | | |
| | | trator indicated on | | | | | | |
| | | PM the agency had | | | | | | |
| | | etency testing on the thought the agency had | | | | | | |
| | | egistration of these | | | | | | |
| | - | Administrator was not | | | | | | |
| | • | Further documentation | | | | | | |
| | • | ompliance prior to exit | | | | | | |
| | _ | e staff did not have any | | | | | | |
| | specific recollec | tion of when the | | | | | | |
| | | egistration may have | | | | | | |
| | | ana State Department of | | | | | | |
| | | ministrator indicated the | | | | | | |
| | | ed a performance | | | | | | |
| | the creation and | an on 1-5-14 regarding | | | | | | |
| | | n accordance with | | | | | | |
| | regulation, rules | | | | | | | |
| | descriptions. | , | | | | | | |
| | - | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| G 215 | 484.36(b)(2)(iii) | | | | | | | |
| | COMPETENCY E | | | | | | | |
| Bldg. 00 | IN-SERVICE TRA | l aide must receive at least | | | | | | |

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Event ID:

0B4Q11

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If continuation sheet

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| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) | | (X3) DATE S | SURVEY | |
|-----------|---------------------|------------------------------|---------------------------------|-----------------------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BU | A. BUILDING <u>00</u> | | COMPLI | ETED |
| | | 157645 | B. W | B. WING | | 02/17/2 | 2015 |
| | | | | CTDEET / | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | 8 | | | | 4 | |
| DUDE U | | ELLO. | | | MERIDIAN STREET SUITE 104 | 4 | |
| PURE HU | OME HEALTH CAR | E LLC | | INDIAN | APOLIS, IN 46260 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | vice training during each | | | | | |
| | | The in-service training | | | | | |
| | - | while the aide is furnishing | | | | | |
| | care to the patient | i. | | | | | |
| | | | G 2 | 15 | An audit tool has been added | to | 03/17/2015 |
| | Based on review | of job description, | | | the front of the personnel files which includes 12h of continui | na | |
| | personnel file re- | view, and interview, the | | | education or prorated equivale | - | |
| | • | ensure home health aides | | | These in-services are offered | | |
| | | 12 hours of continuing | | | hire and three times during the | | |
| | , , | orated equivalent, for 1 of | | | year, Personnel will be | | |
| | _ | - | | | responsible for auditing the file | es | |
| | 8 HHA personne | el files reviewed (N). | | | on a daily basis until files are | | |
| | | | | | complete Once the files are | | |
| | Findings include: | | | | complete, they will be audited | | |
| | | | | | a monthly basis This is a part | of | |
| | 1. Agency job d | escription, copyright | | | our QAPI initiative | | |
| | Briggs, undated, | | | | The HHA Supervisor will be responsible for monitoring the | | |
| | | ice programs to meet | | | corrective actions to ensure th | | |
| | compliance requ | | | | this deficiency is corrected and | | |
| | compnance requ | mements. | | | will not recur | | |
| | | | | | | | |
| | | es for HHA Employee N, | | | | | |
| | date of hire 11/2 | 1/13, failed to evidence | | | | | |
| | 12 hours of cont | inuing education, or | | | | | |
| | prorated equival | ent for 2014. The | | | | | |
| | employee persor | | | | | | |
| | evidence any do | | | | | | |
| | - | | | | | | |
| | continuing educa | auon III 2014. | | | | | |
| | | | | | | | |
| | | 5 at 4:00 PM, upon | | | | | |
| | request, the Alte | rnate Director of | | | | | |
| | Nursing, who su | pervised the HHAs, was | | | | | |
| | | e further documentation | | | | | |
| | demonstrating co | | | | | | |
| | aomononaming of | omphanee. | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | 1 | | İ | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0B4Q11

Facility ID: 012680

If continuation sheet Page 5 of 11

| | OF CORRECTION IDENTIFICATION NUMBER: | A. BUILDING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED |
|---|---|---------------------|---|-----------------------------|
| | 157645 | B. WING | | 02/17/2015 |
| NAME OF PROVIDER OR SUPPLIER PURE HOME HEALTH CARE LLC | | 9333 N | ADDRESS, CITY, STATE, ZIP CODE MERIDIAN STREET SUITE 10 IAPOLIS, IN 46260 | 4 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| N 000 Bldg. 00 | | | | |
| | This was a home health state complaint investigation. | N 000 | | |
| | Complaint #: IN00166167; Substantiated: State deficiencies related to the allegation are cited. | | | |
| | Survey dates: 2-9, 2-10, 2-11, 2-12, 2-13, 2-16, and 2-17-2015 Facility number: 012680 | | | |
| | Surveyor: Deborah Franco, RN, Public Health Nurse Surveyor | | | |
| | Census: Unduplicated skilled admissions last 12 months: 285 Current active: 88 Skilled, 28 Home Health Aide only, 3 Personal Service only | | | |
| | Quality Review: Joyce Elder, MSN, BSN, RN February 26, 2015 | | | |

PRINTED: 03/17/2015 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: 157645 | A. BUILDING B. WING | <u>00</u> | COM | PLETED 7/2015 |
|--------------------------|--|--|---------------------|---|-----|----------------------|
| | PROVIDER OR SUPPLIER | | 9333 N | NDDRESS, CITY, STATE, ZIP CODE MERIDIAN STREET SUITE APOLIS, IN 46260 | 104 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| N 586 Bldg. 00 | receive continuing continuing educati twelve (12) hours December 31, incleight (8) hours in a following subject at (1) Communicate ability to read, write accurate oral prescaregivers, and of staff. (2) Observing, repatient status and furnished. (3) Reading and pulse, and respirate (4) Basic infection universal precaution (5) Basic element changes in body for reported to an aide (6) Maintaining and environment. (7) Recognizing knowledge of eme (8) The physical developmental newith the population health agency, incleiced. | Home health aides must peducation. Such ion shall total at least from January 1 through lusive, with a minimum of eany eight (8) of the areas: ions skills, including the te, and make brief and entations to patients, her home health agency eporting, and documenting the care or service a recording temperature, tion. In control procedures and ons. Ints of body functioning and unction that must be | | | | |

State Form Event ID: 0B4Q11 Facility ID: 012680 If continuation sheet Page 7 of 11

| NAME OF PROVIDER OR SUPPLIER PURE HOME HEALTH CARE LLC (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) and the patient's property. (9) Appropriate and safe techniques in personal hygiene and grooming that include the following: (A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and | | |
|--|-----------|--|
| NAME OF PROVIDER OR SUPPLIER PURE HOME HEALTH CARE LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) and the patient's property. (9) Appropriate and safe techniques in personal hygiene and grooming that include the following: (A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and | COMPLETED | |
| PURE HOME HEALTH CARE LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) and the patient's property. (9) Appropriate and safe techniques in personal hygiene and grooming that include the following: (A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and | | |
| (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) and the patient's property. (9) Appropriate and safe techniques in personal hygiene and grooming that include the following: (A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and | | |
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) and the patient's property. (9) Appropriate and safe techniques in personal hygiene and grooming that include the following: (A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and | | |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) and the patient's property. (9) Appropriate and safe techniques in personal hygiene and grooming that include the following: (A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and | | |
| and the patient's property. (9) Appropriate and safe techniques in personal hygiene and grooming that include the following: (A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and | ION | |
| (9) Appropriate and safe techniques in personal hygiene and grooming that include the following: (A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and | | |
| positioning. (12) Adequate nutrition and fluid intake. (13) Medication assistance. (14) Any other task that the home health agency may choose to have the home health aide perform. Based on review of job description, personnel file review, and interview, the agency failed to ensure home health aides (HHA) received 12 hours of continuing education, or prorated equivalent, for 1 of 8 HHA personnel files reviewed (N). Findings include: 1. Agency job description, copyright Briggs, undated, for HHA states, "Attends in-service programs to meet compliance requirements." 2. Personnel files for HHA Employee N, date of hire 11/21/13, failed to evidence 12 hours of continuing education, or prorated equivalent for 2014. The | 015 | |
| prorated equivalent for 2014. The | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE (| ONSTRUCTION | (X3) DATE SURVEY | |
|--|-----------------------------------|------------------------------|-------------|--|------------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | 157645 | B. WING | | 02/17/2015 |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET | ADDRESS, CITY, STATE, ZIP CODE | |
| While of 1 | KO VIDEK OK SOI I EIEK | | | N MERIDIAN STREET SUITE 104 | 4 |
| PURE HO | OME HEALTH CAR | E LLC | INDIA | NAPOLIS, IN 46260 | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | employee person | | | | |
| | evidence any doo | | | | |
| | continuing educa | ation in 2014. | | | |
| | | | | | |
| | | 5 at 4:00 PM, upon | | | |
| | request, the Alter | | | | |
| | | pervised the HHAs, was | | | |
| | • | e further documentation | | | |
| | demonstrating co | ompliance. | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| N 597 | 410 IAC 17-14-1(I) | | | | · · |
| | Scope of Services | | | | |
| Bldg. 00 | Rule 14 Sec. (1)(I) shall: | (1) The home health aide | | | |
| | | and be in good standing | | | |
| | on the state aide r | - | | | |
| | | | N 597 | Personnel files are being audit | 02/1//2016 |
| | Based on review | of Indiana | | on a daily basis until personne | |
| | Administrative C | Code 410 IAC 17-14-1 (1 | | files are current to ensure that of our home health aides are | l all |
| |)(1)(B), personi | nel record review, and | | qualified by confirming the hor | ne |
| | interview, the ag | ency administrator failed | | health aides are registered and | |
| | to ensure employ | vees were qualified by | | good standing on the state aid | е |
| | confirming the h | ome health aides were | | registry All new hires will be confirmed on the state aide | |
| | • | good standing on the | | registry prior to starting patient | t |
| | _ | y for 5 of 6 currently | | care The Director of Clinical | |
| | | health aide (K, L, M, N, | | Services will be responsible for | r |
| | | es reviewed creating the | | monitoring these corrective | |
| | | et all patients who were | | actions to ensure that this deficiency is corrected and wil | |
| | • | nealth aide services in the | | not recur, | |
| | agency. | | | | |
| | <i>S y</i> · | | | | |
| | | | | | I |

State Form Event ID: 0B4Q11 Facility ID: 012680 If continuation sheet Page 9 of 11

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ULTIPLE CO. JILDING | NSTRUCTION 00 | (X3) DATE COMPL | | |
|---|---|---|------------------------|---|--|--------|----------------------------|
| | | 157645 | B. W | | 00 | 02/17/ | |
| NAME OF PROVIDER OR SUPPLIER PURE HOME HEALTH CARE LLC | | | 9333 N | DDRESS, CITY, STATE, ZIP CODE MERIDIAN STREET SUITE 10 APOLIS, IN 46260 | 4 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | Findings include | | | | | | |
| | 1. Indiana Admit 17-14-1 (1)(1) health agency shensuring that, prindividuals who services on its be requirements of (B) be entered or on the state aide. 2. Personnel recaide, date of hire contact 9-24-13, agency had detergood standing arprior to providin. 3. Personnel recaide, date of hire contact 3-27-13, agency had detergood standing arprior to providin. 4. Personnel recaide, date of hire contact 5-14-14, agency had detergontact 5-14-14, agency had detergontact 5-14-14. | inistrative Code 410 IAC (B) states, "The home hall be responsible for ior to patient contact, the furnish home health aide half meet the this section as follows: n and be in good standing registry." Ford K, a home health 10 7-25-13 and first patient failed to evidence the rmined the aide was in and on the state registry g patient care. Ford L, a home health 10 3-26-13 and first patient failed to evidence the rmined the aide was in and on the state registry g patient care. Ford M, a home health 10 5-12-14 and first patient failed to evidence the rmined the aide was in and on the state registry g patient care. | | | | | |
| | prior to providin | nd on the state registry g patient care. | | | | | |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157645 | | JILDING | NSTRUCTION 00 | (X3) DATE COMPL 02/17 / | ETED | |
|---|--|---|---|---|------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER PURE HOME HEALTH CARE LLC | | 9333 N | DDRESS, CITY, STATE, ZIP CODE MERIDIAN STREET SUITE 10 APOLIS, IN 46260 | 4 | | |
| (X4) ID PREFIX TAG | SUMMARY S' (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| TAG | aide, date of hire patient contact 1 evidence the age aide was in good state registry priccare. 6. Personnel recaide, date of hire contact 7-19-14, agency had deter good standing ar prior to providin 7. The Administ 2-17-14 at 4:00 I completed compabove aides and completed the repersonnel. The Administrating completed the repersonnel of the personnel of the specific recollect application for repease to India Health. The Admagency has started | e 11-21-13 and first 1-23-13, failed to mey had determined the I standing and on the or to providing patient ord O, a home health e 7-14-14 and first patient failed to evidence the rmined the aide was in and on the state registry g patient care. trator indicated on PM the agency had etency testing on the thought the agency had egistration of these Administrator was not further documentation compliance prior to exit e staff did not have any tion of when the egistration may have ana State Department of ministrator indicated the ed a performance an on 1-5-14 regarding | TAG | | | DATE |
| | personnel files in regulation, rules, descriptions. | n accordance with , and agency job | | | | |

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