

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/27/2012
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NAME OF PROVIDER OR SUPPLIER UNIVERSAL HOME HEALTH OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 6409 CONSTITUTION DRIVE FORT WAYNE, IN 46804
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G0000	<p>This was a Home Health federal recertification survey. This was an extended survey.</p> <p>Survey Dates: July 24- 27, 2012</p> <p>Facility Number: 012020</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census Service Type:</p> <p>Skilled: 356 Home Health Aide Only: 0 Personal Service Only: 0 Total: 356</p> <p>Sample:</p> <p>RR w/Home Visits: 6 RR w/o Home Visits: 6 Total Sample: 12</p> <p>Universal Home Health of Indiana is precluded from providing it's own home health aide training and competency evaluation program for a period of 2 years beginning July 31, 2012, to July 31, 2014, for being found out of compliance with the condition of participation 42 CFR 484.36 Home Health Aide Services.</p>	G0000	This Plan of Correction serves as our credible allegation of compliance that Universal Home Health of Indiana has corrected all deficiencies.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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	Quality Review: Joyce Elder, MSN, BSN, RN July 31, 2012			

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G0121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on observation, policy review, and interview, the agency failed to ensure its infection control policy and procedure was followed by all staff for 1 of 6 home visits with the potential to effect all the agency's patients. (#5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> During home visit on 7/26/12 at 9:00 AM with patient #5, employee H, a Home Health Aide (HHA), was observed obtaining a blood pressure with a manual cuff. The HHA failed to clean the blood pressure cuff prior to returning it to the bag. The HHA was also observed assisting the patient with a shower and used the same pair of gloves during the entire shower, including washing the patient's rectal area, which contained blood, and then assisting to rub the patient's head with shampoo and also used the same gloves to dress the patient and clean up bathing supplies. During interview on 7/26/12 at 10:05 AM, employee H indicated they clean the blood pressure cuff pretty frequently, 			G0121	<p>G121 The Administrator has in-serviced all staff on policies and procedures for infection control, proper hand washing, bag technique and universal precautions.</p> <p>The Administrator or designee will perform in-home skills checks for compliance with policies related to infection control, hand washing, bag technique and universal precautions no less than annually. All employees will attend mandatory annual in-services related to infection control, universal precautions and hand washing.</p> <p>Employees found non-compliant with established policies will be subject to re-education, action plans and/ or progressive discipline.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>Completion date 8-1-12</p>		08/01/2012

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	<p>mostly after every use.</p> <p>3. The agency's undated policy titled "Bag Technique," # 9-014.1, was provided on 7/26/12 and employee D indicated this is the currently policy. The policy states, "5. When the visit is completed, reusable equipment will be cleaned using alcohol, soap and water, or other appropriate solution, hands will be washed, and equipment and supplies will be returned to the bag."</p> <p>3. The agency's undated policy titled "Personal Protective Equipment," # 9-007.2, was provided on 7/26 and employee D indicated this is the current policy. The policy states, "C. Gloves are to be changed: 1. Between tasks and procedures on the same patient."</p> <p>4. During interview on 7/26/12 at 1:00 PM, employee D indicated the aide should have changed gloves after the shower was complete and before dressing the patient.</p>			
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G0159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on observation, clinical record review, and interview, the agency failed to ensure all Durable Medical Equipment (DME) was listed on the Plan of Care (POC) for 1 of 6 home visits with clinical record review with the potential to affect all the agency's patients. (#5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During home visit with patient #5 on 7/26/12 at 9:00 AM, the following DME was noted in the home: over the tub assistance grab bar and mounted grab bar at front of bath tub. The Home Health Certification and Plan of Care dated 06/04/2012 - 08/02/2012 failed to list this equipment. 2. On 7/26/12 at 9:30 AM, the patient indicated they use the over the tub grab bar to help them get on and off of the toilet. 	G0159	<p>G159 The Administrator has in-serviced all nursing and therapy staff on the patient care plan to include all Durable Medical Equipment (DME) listed on the Plan of Care.</p> <p>On 7-27-12, an addendum order was obtained for patient #5 to include his bathroom grab bars.</p> <p>The Administrator or designee will audit no less than 10% of clinical records for evidence that the plan of care follows the State and Federal rules and company policy related to the patient's equipment and supplies, ensuring that patient orders will encompass the equipment and supplies required to meet the patient's needs. The clinical record review will include the comprehensive RN assessment and any PT or OT evaluations that may mention current or recommended DME to be included in the plan of</p>	08/01/2012	

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	<p>3. The agency's undated policy titled "Care Planning Process," # 2-018.1, was provided on 7/26 and employee D indicated this is the current policy. The policy states, "2. All clinicians will consider the conclusions of initial and ongoing assessments in their care planning process, including, but not limited to: ... O. Equipment and supplies ... 5. The plan of care will be based upon the physician's (or other authorized licensed independent practitioner's) orders and will encompass the equipment, supplies, and services required to meet the patient's needs."</p> <p>4. The agency's undated policy titled "Initial and Comprehensive Assessment," # 2-007.1, was provided on 7/26 and employee D indicated this is the current policy. The policy states, "3. During the initial and comprehensive patient assessments, all baseline data to be used in the measuring the patient's progress toward goals and other relevant information will be documented in the patient's clinical record, including at least the following information, if applicable: ... L. Equipment presently in the home and potentially needed by patient."</p>		<p>care, as ordered. Audit results will be reported to the Professional Advisory Board/ Quality Assurance Committee no less than quarterly.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>Completion date 8-1-12</p>				

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G0202	<p>484.36 HOME HEALTH AIDE SERVICES</p> <p>Based on employee file review and interview, it was determined the agency failed to ensure the competency requirements of the Home Health Aide were met prior to the aide proving care for 2 of 2 HHA files reviewed with the potential to affect all agency's patients (See G 211 and G 212), failed to ensure the competency evaluation reflected that the required skills were evaluated with a patient or pseudo patient for 1 of 2 HHA files reviewed with the potential to affect all agency's patients (G 218), failed to ensure documentation evidenced competency evaluation requirements of the Home Health Aide (HHA) were met prior to the aide proving care for 2 of 2 HHA files reviewed with the potential to affect all agency's patients (See G 221), and failed to ensure the Home Health Aide provided care as ordered on the Aide Care Plan for 1 of 5 clinical records reviewed with Home Health Aide Services ordered (See G 225).</p> <p>The cumulative effect of these systemic problems resulted in the agency being unable to meet the requirements of the Condition of Participation 484.36 Home health aide services.</p>	G0202	<p>G202 Effective 7-28-12 thru 8-2-12 the Agency's patients were seen by an RN until the Agency's CNA's completed the State required competency assessment evaluation and Certified Home Health Aide testing performed by another approved, Indiana licensed home health agency RN. On 7-31-12, agency CNAs were tested and able to successfully complete competency evaluation using a simulated patient environment by another Indiana licensed Home Care Agency's RN Administrator.</p> <p>The Administrator or designee will verify and validate upon hire that Home Health Aides are listed and in good standing on the State Home Health Aide Registry. Administrator or designee will arrange for new hire Home Health Aides to have competency evaluated by another Indiana licensed Home Health Agency RN prior to first patient contact, using demonstrated skills completed with a pseudo patient.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>Completion date 7-31-12</p>	07/31/2012			

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G0211	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI An individual may furnish home health aide services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this paragraph.</p> <p>Based on employee file review and interview, the agency failed to ensure the competency evaluation requirements of the Home Health Aide (HHA) were met prior to the aide proving care for 2 of 2 HHA files reviewed with the potential to affect all agency's patients. (E, H)</p> <p>Findings include:</p> <p>1. Employee file E, date of hire (DOH) 2/18/10 and first patient contact date 2/24/10, contained a Certified Home Health Aide test grading sheet dated 2/24/10. This document failed to evidence the test had been graded.</p> <p>Employee E's Initial Competency Assessment Skills Checklist indicates the Date of Employment to be 2/25/10. The file failed to evidence the employee was evaluated for skills prior to 2/24/10, the date of first patient contact. It is dated 2/27/10, 3/1/10, and 3/5/10.</p> <p>2. Employee file H, DOH 4/22/11 and</p>			G0211	<p>G211 Effective 7-28-12 thru 8-3-12 the Agency's patients were seen by an RN until the Agency's CNA's completed the State required competency assessment evaluation and Certified Home Health Aide testing performed by another approved, Indiana licensed home health agency RN. On 7-31-12, agency CNAs were tested and able to successfully complete competency evaluation using a simulated patient environment by another Indiana licensed Home Care Agency's RN Administrator. The Administrator or designee will verify and validate upon hire that Home Health Aides are listed and in good standing on the State Home Health Aide Registry. Administrator or designee will arrange for new hire Home Health Aides to have competency evaluated by another Indiana licensed Home Health Agency RN prior to first patient contact, using demonstrated skills completed with a pseudo patient. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion date</p>		08/03/2012

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	<p>first patient contact date 5/3/11, contained a Certified Home Health Aide test grading sheet dated 8/25/11. This document failed to evidence a grade.</p> <p>Employee H's Initial/Annual Competency Assessment Skills Checklist failed to evidence the employee was evaluated for skills prior to 5/3/11, the date of first patient contact. It is dated 6/30/11 and failed to evidence which skills were performed using verbal or demonstration methods.</p> <p>3. During interview on 7/24/12 at 10:45 AM, employee D indicated they were not sure where the HHA's received the tests. Also there was a previous Director of Nursing in 2009 - 2010 who observed skills competencies for employee E.</p>		8-3-12		

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G0212	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.</p> <p>Based on employee file review and interview, the agency failed to ensure the competency evaluation requirements of the Home Health Aide (HHA) were met prior to the aide providing care for 2 of 2 HHA files reviewed with the potential to affect all agency's patients. (E, H)</p> <p>Findings include:</p> <p>1. Employee file E, date of hire (DOH) 2/18/10 and first patient contact date 2/24/10, contained a Certified Home Health Aide test grading sheet dated 2/24/10. This document failed to evidence the test had been graded.</p> <p>Employee E's Initial Competency Assessment Skills Checklist indicates the Date of Employment to be 2/25/10. The file failed to evidence the employee was evaluated for skills prior to 2/24/10, the date of first patient contact. It is dated 2/27/10, 3/1/10, and 3/5/10.</p> <p>2. Employee file H, DOH 4/22/11 and first patient contact date 5/3/11, contained</p>	G0212	<p>G212 Effective 7-28-12 thru 8-2-12 the Agency's patients were seen by an RN until the Agency's CNA's completed the State required competency assessment evaluation and Certified Home Health Aide testing performed by another approved, Indiana licensed home health agency RN. On 7-31-12, agency CNAs were tested and able to successfully complete competency evaluation using a simulated patient environment by another Indiana licensed Home Care Agency's RN Administrator.</p> <p>The Administrator or designee will verify and validate upon hire that Home Health Aides are listed and in good standing on the State Home Health Aide Registry. Administrator or designee will arrange for new hire Home Health Aides to have competency evaluated by another Indiana licensed Home Health Agency RN prior to first patient contact, using demonstrated skills completed with a pseudo patient.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this</p>	07/31/2012

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	<p>a Certified Home Health Aide test grading sheet dated 8/25/11. This document failed to evidence a grade.</p> <p>Employee H's Initial/Annual Competency Assessment Skills Checklist failed to evidence the employee was evaluated for skills prior to 5/3/11, the date of first patient contact. It is dated 6/30/11 and failed to evidence which skills were performed using verbal or demonstration methods.</p> <p>3. During interview on 7/24/12 at 10:45 AM, employee D indicated they were not sure where the HHA's received the tests. Also there was a previous Director of Nursing in 2009 - 2010 who observed skills competencies for employee E.</p>		<p>deficiency is corrected and will not recur.</p> <p>Completion date 7-31-12</p>				

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G0218	<p>484.36(b)(3)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section must be evaluated after observation of the aides performance of the tasks with a patient. The other subject areas in paragraph (a)(1) of this section may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient.</p> <p>Based on employee file review, the agency failed to ensure the competency evaluation reflected that the required skills were evaluated with a patient or pseudo patient for 1 of 2 HHA files reviewed with the potential to affect all agency's patients. (H)</p> <p>Findings include:</p> <p>Employee file H, DOH 4/22/11 and first patient contact date 5/3/11, contained an Initial / Annual Competency Assessment Skills Checklist that failed to evidence the employee was evaluated for skills prior to 5/3/11, the date of first patient contact. It is dated 6/30/11 and failed to evidence which skills were performed using verbal or demonstration methods.</p>	G0218	<p>G218 Effective 7-28-12 thru 8-2-12 the Agency's patients were seen by an RN until the Agency's CNA's completed the State required competency assessment evaluation and Certified Home Health Aide testing performed by another approved, Indiana licensed home health agency RN. On 7-31-12, agency CNAs were tested and able to successfully complete competency evaluation using a simulated patient environment by another Indiana licensed Home Care Agency's RN Administrator.</p> <p>The Administrator or designee will verify and validate upon hire that Home Health Aides are listed and in good standing on the State Home Health Aide Registry. Administrator or designee will arrange for new hire Home Health Aides to have competency evaluated by another Indiana licensed Home Health Agency RN prior to first patient contact, using demonstrated skills</p>	07/31/2012	

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			<p>completed with a pseudo patient.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>Completion date 7-31-12</p>	

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G0221	<p>484.36(b)(5) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA must maintain documentation which demonstrates that the requirements of this standard are met.</p> <p>Based on employee file review and interview, the agency failed to ensure documentation evidenced competency evaluation requirements of the Home Health Aide (HHA) were met prior to the aide proving care for 2 of 2 HHA files reviewed with the potential to affect all agency's patients. (E, H)</p> <p>Findings include:</p> <p>1. Employee file E, date of hire (DOH) 2/18/10 and first patient contact date 2/24/10, contained a Certified Home Health Aide test grading sheet dated 2/24/10. This document failed to evidence the test had been graded.</p> <p>Employee E's Initial Competency Assessment Skills Checklist indicates the Date of Employment to be 2/25/10. The file failed to evidence the employee was evaluated for skills prior to 2/24/10, the date of first patient contact. It is dated 2/27/10, 3/1/10, and 3/5/10.</p> <p>2. Employee file H, DOH 4/22/11 and first patient contact date 5/3/11, contained a Certified Home Health Aide test</p>	G0221	<p>G221 Effective 7-28-12 thru 8-2-12 the Agency's patients were seen by an RN until the Agency's CNA's completed the State required competency assessment evaluation and Certified Home Health Aide testing performed by another approved, Indiana licensed home health agency RN. On 7-31-12, agency CNAs were tested and able to successfully complete competency evaluation using a simulated patient environment by another Indiana licensed Home Care Agency's RN Administrator.</p> <p>The Administrator or designee will verify and validate upon hire that Home Health Aides are listed and in good standing on the State Home Health Aide Registry. Administrator or designee will arrange for new hire Home Health Aides to have competency evaluated by another Indiana licensed Home Health Agency RN prior to first patient contact, using demonstrated skills completed with a pseudo patient.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not</p>	07/31/2012

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	<p>grading sheet dated 8/25/11. This document failed to evidence a grade.</p> <p>Employee H's Initial/Annual Competency Assessment Skills Checklist failed to evidence the employee was evaluated for skills prior to 5/3/11, the date of first patient contact. It is dated 6/30/11 and failed to evidence which skills were performed using verbal or demonstration methods.</p> <p>3. During interview on 7/24/12 at 10:45 AM, employee D indicated they were not sure where the HHA's received the tests. Also there was a previous Director of Nursing in 2009 - 2010 who observed skills competencies for employee E.</p>		<p>recur. Completion date 7-31-12</p>		

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G0225	<p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.</p> <p>Based on clinical record review and interview, the agency failed to ensure the Home Health Aide provided care as ordered on the Aide Care Plan for 1 of 5 clinical records reviewed with Home Health Aide Services ordered. (9)</p> <p>Findings include:</p> <p>1. Clinical record #9, start of care date 01/06/12, contained an Aide Care Plan dated 1/6/12 with orders for the Aide to do the following tasks each visit: Personal Care, Assist with Dressing, Shampoo, Skin care, Check Pressure Areas, and Nail Care.</p> <p>a. The Aide Weekly Visit Record dated 1/30/12 failed to evidence the aide provided Personal Care, Assist with Dressing, Shampoo, Check Pressure Areas, and Nail Care.</p> <p>b. The Aide Weekly Visit Record dated 2/2/12 failed to evidence the aide provided Personal Care, Assist with Dressing, Shampoo, Skin Care, and Check Pressure Areas.</p>	G0225	<p>G225 By 8-1-12 Agency Home Health Aides and nurses were in-serviced on the policy and standard for the Home Health Aide plan of care.</p> <p>The Administrator or designee will audit no less than 10% of active and closed clinical records for evidence that the Home Health Aide documentation supports the Home Health Aide Services ordered.</p> <p>Results will be reported to the Professional Advisory Board/ Quality Assurance committee no less than quarterly.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>Completion date 8-1-12</p>	08/01/2012			

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	<p>c. The Aide Weekly Visit Record dated 1/24/12 failed to evidence the aide provided Personal Care, Assist with Dressing, Skin Care, and Nail Care.</p> <p>d. The Aide Weekly Visit Record dated 1/27/12 failed to evidence the aide provided Personal Care, Assist with Dressing, Shampoo, Skin Care, and Nail Care.</p> <p>e. The Aide Weekly Visit Record dated 1/17/12 and 1/20/12 failed to evidence the aide provided Personal Care, Shampoo, Skin Care, and Nail Care.</p> <p>f. The Aide Weekly Visit Record dated 1/10/12 failed to evidence the aide provided Shampoo and Skin Care.</p> <p>g. The Aide Weekly Visit Record dated 1/30/12 failed to evidence the aide provided Skin Care and Nail Care.</p> <p>2. During interview on 7/26/12 at 1:00 PM, employee D indicated the aide should have noted if the patient refused the assigned tasks.</p>				

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G0236	<p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the Clinical Supervisor or designee reviewed the plan of care for accuracy of documents signed by the Registered Nurse (RN) for 1 of 12 records reviewed with the potential to effect all the agency's patients. (3)</p> <p>Findings include:</p> <p>1. Clinical record #3 contained a Home Health Certification and Plan of Care with a Start of Care Date 07/20/2012. The Comprehensive Assessment was dated 7/20/12 on page 1 of the document, but dated 7/19/12 on page 20 of the document. The interdisciplinary note is dated 7/19/12. The Fall Risk Management Plan is dated 7/19-20. The following listed documents are dated 7/19/12: Patient Health Questionnaire, Braden Scale document, Discipline Triggers</p>	G0236	<p>G236 On 7-27-12 the RN completed a data entry error correction and narrative note for all misdated forms to reflect the correct assessment date of 7-20-12 as follows: Comprehensive Assessment page 20, Interdisciplinary Note, Fall Risk Management Plan, Patient Health Questionnaire, Braden Scale document, Discipline Triggers document, Hospital Risk Assessment and Medication Profile.</p> <p>On 8-1-12 nurses and all staff were inserviced on accuracy of documentation and clinical records standards.</p> <p>The Director of Clinical Services or designee will review the plan of care for all patients and will audit no less than 10% of all clinical records for evidence that chart documents are accurately signed by clinicians and employees documenting in the patient's record.</p>	08/01/2012			

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	<p>document, and the Hospitalization Risk Assessment document. The Medication Profile is dated 7/15/12.</p> <p>2. On 7/26/12 at 1:10 PM, employee D indicated the nurse had to have misdated the paperwork for 7/19 and verified the nurse did not see the patient until 7/20/12.</p> <p>3. The agency's policy titled "Initial and Comprehensive Assessment," # 2-007.1, was provided on 7/26 and employee D indicated this is the current policy. The policy states, "6. The Clinical Supervisor or designee will be responsible for the review of the plan of care."</p>		<p>Results will be reported to the Professional Advisory Board/ Quality Assurance Committee no less than quarterly.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>Completion date 8-1-12</p>	

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N0000	<p>This was a Home Health state licensure survey.</p> <p>Survey Dates: July 24- 27, 2012</p> <p>Facility Number: 012020</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census Service Type:</p> <p>Skilled: 356 Home Health Aide Only: 0 Personal Service Only: 0 Total: 356</p> <p>Sample:</p> <p>RR w/Home Visits: 6 RR w/o Home Visits: 6 Total Sample: 12</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 31, 2012</p>			N0000	<p>This Plan of Correction serves as our credible allegation of compliance that Universal Home Health of Indiana has corrected all deficiencies.</p>		

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N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, policy review, and interview, the agency failed to ensure its infection control policy and procedure was followed by all staff for 1 of 6 home visits with the potential to effect all the agency's patients. (#5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During home visit on 7/26/12 at 9:00 AM with patient #5, employee H, a Home Health Aide (HHA), was observed obtaining a blood pressure with a manual cuff. The HHA failed to clean the blood pressure cuff prior to returning it to the bag. The HHA was also observed assisting the patient with a shower and used the same pair of gloves during the entire shower, including washing the patient's rectal area, which contained blood, and then assisting to rub the patient's head with shampoo and also used the same gloves to dress the patient and clean up bathing supplies. 2. During interview on 7/26/12 at 10:05 AM, employee H indicated they clean the 	N0470	<p>N470 The Administrator has in-serviced all staff on policies and procedures for infection control, proper hand washing, bag technique and universal precautions.</p> <p>The Administrator or designee will perform in-home skills checks for compliance with policies related to infection control, hand washing, bag technique and universal precautions no less than annually. All employees will attend mandatory annual in-services related to infection control, universal precautions and hand washing.</p> <p>Employees found non-compliant with established policies will be subject to re-education, action plans and/ or progressive discipline.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion date 8-1-12</p>	08/01/2012

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	<p>blood pressure cuff pretty frequently, mostly after every use.</p> <p>3. The agency's undated policy titled "Bag Technique," # 9-014.1, was provided on 7/26/12 and employee D indicated this is the currently policy. The policy states, "5. When the visit is completed, reusable equipment will be cleaned using alcohol, soap and water, or other appropriate solution, hands will be washed, and equipment and supplies will be returned to the bag."</p> <p>3. The agency's undated policy titled "Personal Protective Equipment," # 9-007.2, was provided on 7/26 and employee D indicated this is the current policy. The policy states, "C. Gloves are to be changed: 1. Between tasks and procedures on the same patient."</p> <p>4. During interview on 7/26/12 at 1:00 PM, employee D indicated the aide should have changed gloves after the shower was complete and before dressing the patient.</p>				

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N0524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p> <p>(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on observation, clinical record review, and interview, the agency failed to ensure all Durable Medical Equipment (DME) was listed on the Plan of Care (POC) for 1 of 6 home visits with clinical record review with the potential to affect all the agency's patients. (#5)</p> <p>Findings include:</p> <p>1. During home visit with patient #5 on 7/26/12 at 9:00 AM, the following DME</p>	N0524	<p>N524 The Administrator has in-serviced all nursing and therapy staff on the patient care plan to include all Durable Medical Equipment (DME) listed on the Plan of Care.</p> <p>On 7-27-12, an addendum order was obtained for patient #5 to include his bathroom grab bars.</p> <p>The Administrator or designee will audit no less than 10% of clinical</p>	07/27/2012			

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	<p>was noted in the home: over the tub assistance grab bar and mounted grab bar at front of bath tub. The Home Health Certification and Plan of Care dated 06/04/2012 - 08/02/2012 failed to list this equipment.</p> <p>2. On 7/26/12 at 9:30 AM, the patient indicated they use the over the tub grab bar to help them get on and off of the toilet.</p> <p>3. The agency's undated policy titled "Care Planning Process," # 2-018.1, was provided on 7/26 and employee D indicated this is the current policy. The policy states, "2. All clinicians will consider the conclusions of initial and ongoing assessments in their care planning process, including, but not limited to: ... O. Equipment and supplies ... 5. The plan of care will be based upon the physician's (or other authorized licensed independent practitioner's) orders and will encompass the equipment, supplies, and services required to meet the patient's needs."</p> <p>4. The agency's undated policy titled "Initial and Comprehensive Assessment," # 2-007.1, was provided on 7/26 and employee D indicated this is the current policy. The policy states, "3. During the initial and comprehensive patient</p>		<p>records for evidence that the plan of care follows the State and Federal rules and company policy related to the patient's equipment and supplies, ensuring that patient orders will encompass the equipment and supplies required to meet the patient's needs. The clinical record review will include the comprehensive RN assessment and any PT or OT evaluations that may mention current or recommended DME to be included in the plan of care, as ordered. Audit results will be reported to the Professional Advisory Board/ Quality Assurance Committee no less than quarterly.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>Completion date 7-27-12</p>		

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	assessments, all baseline data to be used in the measuring the patient's progress toward goals and other relevant information will be documented in the patient's clinical record, including at least the following information, if applicable: ... L. Equipment presently in the home and potentially needed by patient."			

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N0596	<p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) 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 requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and</p> <p>Based on employee file review and interview, the agency failed to ensure the competency requirements of the Home Health Aide (HHA) were met prior to the aide proving care for 2 of 2 HHA files reviewed with the potential to affect all agency's patients. (E, H)</p> <p>Findings include:</p> <p>1. Employee file E, date of hire (DOH) 2/18/10 and first patient contact date 2/24/10, contained a Certified Home Health Aide test grading sheet dated 2/24/10. This document failed to evidence the test had been graded.</p> <p>Employee E's Initial Competency Assessment Skills Checklist indicates the Date of Employment to be 2/25/10. The file failed to evidence the employee was evaluated for skills prior to 2/24/10, the date of first patient contact. It is dated 2/27/10, 3/1/10, and 3/5/10.</p>	N0596	<p>N596 Effective 7-28-12 thru 8-2-12 the Agency's patients were seen by an RN until the Agency's CNA's completed the State required competency assessment evaluation and Certified Home Health Aide testing performed by another approved, Indiana licensed home health agency RN. On 7-31-12, agency CNAs were tested and able to successfully complete competency evaluation using a simulated patient environment by another Indiana licensed Home Care Agency's RN Administrator.</p> <p>The Administrator or designee will verify and validate upon hire that Home Health Aides are listed and in good standing on the State Home Health Aide Registry. Administrator or designee will arrange for new hire Home Health Aides to have competency evaluated by another Indiana licensed Home Health Agency RN prior to first patient contact, using demonstrated skills</p>	07/31/2012			

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	<p>2. Employee file H, DOH 4/22/11 and first patient contact date 5/3/11, contained a Certified Home Health Aide test grading sheet dated 8/25/11. This document failed to evidence a grade.</p> <p>Employee H's Initial/Annual Competency Assessment Skills Checklist failed to evidence the employee was evaluated for skills prior to 5/3/11, the date of first patient contact. It is dated 6/30/11 and failed to evidence which skills were performed using verbal or demonstration methods.</p> <p>3. During interview on 7/24/12 at 10:45 AM, employee D indicated they were not sure where the HHA's received the tests. Also there was a previous Director of Nursing in 2009 - 2010 who observed skills competencies for employee E.</p>		<p>completed with a pseudo patient.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>Completion date 7-31-12</p>		

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N0597	<p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry.</p> <p>Based on employee file review, job description review, and interview, the agency failed to ensure the Home Health Aides (HHA) were entered and in good standing on the Indiana State Aide Registry for 2 of 2 HHA files reviewed with the potential to affect all agency's patients. (E, H)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Employee file E, date of hire (DOH) 2/18/10, failed to evidence the agency had checked to ensure this aide was entered on and in good standing on the State Aide Registry. 2. Employee file H, DOH 4/22/11, failed to evidence the agency had checked to ensure this aide was entered on and in good standing on the State Aide Registry. 3. During interview on 7/24/12 at 10:45 AM, employee D indicated the agency had not checked to ensure the aide was entered on and in good standing on the Home Health Aide Registry. 			N0597	<p>N597 Effective 7-31-12 all agency Home Health Aides were entered on and in good standing with the Indiana State Aide Registry.</p> <p>Administrator or designee will verify upon hire and semi-annually that Home Health Aides remain on the Indiana State Aide Registry in good standing.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>Completion date 7-31-12</p>		07/31/2012

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N0598	<p>410 IAC 17-14-1(l)(2) Scope of Services Rule 14 Sec. 1(l)(2) The home health agency shall maintain documentation which demonstrates that the requirements of this subsection and subsection (h) of this rule were met.</p> <p>Based on employee file review and interview, the agency failed to ensure documentation evidenced the competency requirements of the Home Health Aide were met prior to the aide proving care and the aide was entered on and in good standing on the state aide registry for 2 of 2 HHA files reviewed with the potential to affect all agency's patients. (E, H)</p> <p>Findings include:</p> <p>1. Employee file E, date of hire (DOH) 2/18/10 and first patient contact date 2/24/10, contained a Certified Home Health Aide test grading sheet dated 2/24/10. This document failed to evidence the test had been graded.</p> <p>A. Employee E's Initial Competency Assessment Skills Checklist indicates the Date of Employment to be 2/25/10. The file failed to evidence the employee was evaluated for skills prior to 2/24/10, the date of first patient contact. It is dated 2/27/10, 3/1/10, and 3/5/10.</p>	N0598	<p>N598 Effective 7-28-12 thru 8-2-12 the Agency's patients were seen by an RN until the Agency's CNA's completed the State required competency assessment evaluation and Certified Home Health Aide testing performed by another approved, Indiana licensed home health agency RN. On 7-31-12, agency CNAs were tested and able to successfully complete competency evaluation using a simulated patient environment by another Indiana licensed Home Care Agency's RN Administrator.</p> <p>The Administrator or designee will verify and validate upon hire that Home Health Aides are listed and in good standing on the State Home Health Aide Registry. Administrator or designee will arrange for new hire Home Health Aides to have competency evaluated by another Indiana licensed Home Health Agency RN prior to first patient contact, using demonstrated skills completed with a pseudo patient.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this</p>	07/31/2012	

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	<p>B. Employee file E failed to evidence the agency had checked to ensure this aide was entered on and in good standing on the State Aide Registry.</p> <p>2. Employee file H, DOH 4/22/11 and first patient contact date 5/3/11, contained a Certified Home Health Aide test grading sheet dated 8/25/11. This document failed to evidence a grade.</p> <p>A. Employee H's Initial/Annual Competency Assessment Skills Checklist failed to evidence the employee was evaluated for skills prior to 5/3/11, the date of first patient contact. It is dated 6/30/11 and failed to evidence which skills were performed using verbal or demonstration methods.</p> <p>B. Employee file H failed to evidence the agency had checked to ensure this aide was entered on and in good standing on the State Aide Registry.</p> <p>3. During interview on 7/24/12 at 10:45 AM, employee D indicated they were not sure where the HHA's received the tests. Also there was a previous Director of Nursing in 2009 - 2010 who observed skills competencies for employee E. Employee D also indicated the agency had not checked to ensure the aide was entered on and in good standing on the</p>		<p>deficiency is corrected and will not recur. Completion date 7-31-12</p>		

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	Home Health Aide Registry.			

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N0608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the Clinical Supervisor or designee reviewed the plan of care for accuracy of documents signed by the Registered Nurse (RN) for 1 of 12 records reviewed with the potential to effect all the agency's patients. (3)</p> <p>Findings include:</p> <p>1. Clinical record #3 contained a Home Health Certification and Plan of Care with a Start of Care Date 07/20/2012. The Comprehensive Assessment was dated 7/20/12 on page 1 of the document, but</p>	N0608	<p>N608 On 7-27-12 the RN completed a data entry error correction and narrative note for all misdated forms to reflect the correct assessment date of 7-20-12 as follows: Comprehensive Assessment page 20, Interdisciplinary Note, Fall Risk Management Plan, Patient Health Questionnaire, Braden Scale document, Discipline Triggers document, Hospital Risk Assessment and Medication Profile.</p> <p>On 8-1-12 nurses and all staff were inserviced on accuracy of documentation and clinical records standards.</p>	08/01/2012	

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	<p>dated 7/19/12 on page 20 of the document. The interdisciplinary note is dated 7/19/12. The Fall Risk Management Plan is dated 7/19-20. The following listed documents are dated 7/19/12: Patient Health Questionnaire, Braden Scale document, Discipline Triggers document, and the Hospitalization Risk Assessment document. The Medication Profile is dated 7/15/12.</p> <p>2. On 7/26/12 at 1:10 PM, employee D indicated the nurse had to have misdated the paperwork for 7/19 and verified the nurse did not see the patient until 7/20/12.</p> <p>3. The agency's policy titled "Initial and Comprehensive Assessment," # 2-007.1, was provided on 7/26 and employee D indicated this is the current policy. The policy states, "6. The Clinical Supervisor or designee will be responsible for the review of the plan of care."</p>		<p>The Director of Clinical Services or designee will review the plan of care for all patients and will audit no less than 10% of all clinical records for evidence that chart documents are accurately signed by clinicians and employees documenting in the patient's record.</p> <p>Results will be reported to the Professional Advisory Board/ Quality Assurance Committee no less than quarterly.</p> <p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>Completion date 8-1-12</p>		

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N0610	<p>410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the Clinical Supervisor or designee reviewed the plan of care for accuracy of documents signed by the Registered Nurse (RN) for 1 of 12 records reviewed with the potential to effect all the agency's patients. (3)</p> <p>Findings include:</p> <p>1. Clinical record #3 contained a Home Health Certification and Plan of Care with a Start of Care Date 07/20/2012. The Comprehensive Assessment was dated 7/20/12 on page 1 of the document, but dated 7/19/12 on page 20 of the document. The interdisciplinary note is dated 7/19/12. The Fall Risk Management Plan is dated 7/19-20. The following listed documents are dated 7/19/12: Patient Health Questionnaire, Braden Scale document, Discipline Triggers document, and the Hospitalization Risk Assessment document. The Medication Profile is dated 7/15/12.</p> <p>2. On 7/26/12 at 1:10 PM, employee D</p>	N0610	<p>N610 On 7-27-12 the RN completed a data entry error correction and narrative note for all misdated forms to reflect the correct assessment date of 7-20-12 as follows: Comprehensive Assessment page 20, Interdisciplinary Note, Fall Risk Management Plan, Patient Health Questionnaire, Braden Scale document, Discipline Triggers document, Hospital Risk Assessment and Medication Profile.</p> <p>On 8-1-12 nurses and all staff were inserviced on accuracy of documentation and clinical records standards.</p> <p>The Director of Clinical Services or designee will review the plan of care for all patients and will audit no less than 10% of all clinical records for evidence that chart documents are accurately signed by clinicians and employees documenting in the patient's record.</p> <p>Results will be reported to the Professional Advisory Board/ Quality Assurance Committee no less than quarterly.</p>	08/01/2012			

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	<p>indicated the nurse had to have misdated the paperwork for 7/19 and verified the nurse did not see the patient until 7/20/12.</p> <p>3. The agency's policy titled "Initial and Comprehensive Assessment," # 2-007.1, was provided on 7/26 and employee D indicated this is the current policy. The policy states, "6. The Clinical Supervisor or designee will be responsible for the review of the plan of care."</p>		<p>The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>Completion date 8-1-12</p>	