

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157540	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2012
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NAME OF PROVIDER OR SUPPLIER DAYBREAK & VISITING NURSE CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1304 MAIN ST ANDERSON, IN 46016
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G0000	<p>This visit was for a federal home health recertification that resulted in an extended survey.</p> <p>Survey dates: August 13, 14, 15, 16, 20, and 21, 2012</p> <p>Facility #: 5832</p> <p>Medicaid #: 200379540A</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor</p> <p>Daybreak Visiting Nurse Care, LLC. is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years beginning August 24, 2012, due to being found of of compliance with the Conditions of Participation 484.32: Therapy Services and 484.36: Home Health Aide Services.</p> <p>Agency Census: Skilled Patients 143 Home Health Aide Only 42 Personal Service Only 62 Total 247</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p>	G0000		

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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	August 24, 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. Based on observation, interview, and document and policy review, the agency failed to ensure staff followed professional standards in furnishing home health aide services in 2 of 2 home health aide visits observed with the potential to effect all patients who receive home health aide services. (# 3 & 4)</p> <p>Findings:</p> <p>1. On August 15, 2012, at 12:30 PM, this surveyor met Employee D, a home health aide, at the home of patient # 4 to observe a bed bath. The patient had a diagnosis of Fitting / Adjustment of Urinary Catheter, neurogenic Bladder, Morbid Obesity, Late Effect CVA, and Bed Confinement Status. The home health aide (HHA) prepared two tubs of water and two sets of washcloths and towels. She washed the patient's body, legs, feet and abdominal fold. Without changing the water, she then washed the perineal area, helped the patient roll to the side, washed the rectum and the catheter tubing that was covered with stool, and then the back. She proceeded to make the bed while it</p>	G0121	<ul style="list-style-type: none"> ·Home Health Aides will complete in-service training to ensure compliance with agency policy and accepted standards for personal care. ·Non-compliance will be grounds for termination. ·Home Health Aides will complete in-service training for special equipment (Hoyer Lift) from a qualified therapist. ·Home Health Aides will complete in-service training for safe patient transfer techniques from a qualified therapist. ·The agency will obtain the operation manual for special equipment agency patients are using and incorporate the information in the in-service training material. ·Patients, who do not receive skilled services but do receive Home Health Aide services, will be supervised by an RN every 30 days while the HHA is providing care. ·The DON will immediately begin meeting every Home Health Aide in patient homes to observe the care provided, the performance of the Home Health Aide, and to identify the need for additional in-service training. ·In order to prevent 	09/20/2012			

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	<p>was occupied. In helping the patient to sit on the side of the bed, the HHA grabbed the morbidly obese patient by the upper left arm, which has limited mobility from a stroke, and pulled on the arm instead of setting her feet and using her legs and arms and the patient's shoulder as a fulcrum to prevent injury to both patient and employee.</p> <p>A. On August 16, 2012, at 2:25 PM, Employee B indicated the HHAs were instructed to change the water before washing the perineal area. She also indicated this patient is prone to urinary tract infections. She indicated the HHAs had been instructed on proper body mechanics.</p> <p>B. The website http://www.nursingassistanteducation.com identifies how to give a bed bath and includes instructions on performing perineal care for men and women who do not have a perineal catheter. The instructions state, "Fill the bath basin with clean water at 110 degrees ... and wash, rinse and dry the rectal area." The instructions include specific instructions on how to wash the perineal area before the rectal area which is different for men and women.</p> <p>2. On August August 16, 2012, at 11:30</p>		<p>re-occurrence, the DON will see every patient admitted/recertified who is receiving Home Health Aide services, to ensure the HHA assignment sheet is patient specific. The DON will verify the Home Health Aide assigned to the care has documented skill for that patient's care needs.</p> <p>The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained.</p>				

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	<p>AM, Employee F and H, both HHAs, were at the home of patient # 3 to perform a bed bath and Hoyer transfer. The patient receives home health aide services only. The patient has a diagnosis of Late Effect Cardiovascular Accident. The senior aide, Employee H, prepared two tubs of water with two sets of washcloths and towels. She washed the face, upper torso, and legs of the patients. Without changing the water she washed the abdominal area, scrotal area, and then pulled back the foreskin and washed the penis. Employee F was helping with the rolling of the patient. The patient's feet were not washed as they were bloody and had bandages on them. After the patient was bathed and dressed, they prepared the patient for transfer to be up for the day. Employee F and H placed the Hoyer sling under the patient, placed the Hoyer legs under the bed (they did not open the Hoyer legs for stability), attached the rings of the sling to the cross arm of the Hoyer, and used the electronic controls to lift the patient. Employee H placed a pillow between the patient's knees and the upright bar of the Hoyer as to not bang the patient's knees and feet. She, walking backwards, guided the Invacare Reliant 450 Hoyer while Employee F stabilized the swinging patient from behind down the approximately 10 foot carpeted hallway and across the approximate 15</p>			

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	<p>foot carpeted living room to the motorized chair. The patient was then successfully lowered into the chair and prepared for the day.</p> <p>A. Employee E indicated they do not wash the patient's feet because the family member does the wound care.</p> <p>B. The family member indicated the would clinic educated the family member on how to soak the feet and how to bandage the feet. The patient had some toe nails get infected and they had been working for quite a while to clear it up. The family member had instructed the HHAs not to wash the feet.</p> <p>C. On 8/20/12 at 10:30 AM, the Administrator indicated they did not have a manual for the Hoyer as the Hoyer was not provided by the agency. The HHAs, Employees F and H, had taken the written test for safety that had 3 questions about the Hoyer. She also indicated there was no documentation the HHAs had performed a competency for any Hoyer.</p> <p>D. On 8/20/12 at 11:15 AM, Employee H indicated the supervising nurse had not been in the home when the aides were providing care to observe the care being given.</p>				

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	<p>E. A policy titled "Home Health Aide Supervision", 4.11.1, Revised 2009, states, "If home health aide services are provided by the Agency to a patient who is not receiving skilled care (Nursing, PT, OT or SLP), a RN must make a supervisory visit to the patients home no less frequently than every 30 days. Each of these supervisory visits must occur while the Home Health Aide is providing care to the patient."</p> <p>F. The operation manual for the Invacare Reliant 450 (Hoyer) states, "2.2 Operating Information General</p> <p>WARNING DO NOT use this product or any available optional equipment without first completely reading and understanding these instructions and any additional instructional material such as owner ' s manuals, service manuals or instruction sheets supplied with this product or optional equipment. If you are unable to understand the warnings, cautions or instructions, contact a healthcare professional, dealer or technical personnel before attempting to use this equipment - otherwise, injury or damage may occur.</p> <p>ACCESSORIES WARNING Invacare products are specifically designed and manufactured for use in</p>				

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	<p>conjunction with Invacare accessories. Accessories designed by other manufacturers have not been tested by Invacare and are not recommended for use with Invacare products.</p> <p>! NOTICE THE INFORMATION CONTAINED IN THIS DOCUMENT IS SUBJECT TO CHANGE WITHOUT NOTICE.</p> <p>WARNING The Invacare patient lift is NOT a transport device. It is intended to transfer an individual from one resting surface to another (such as a bed to a wheelchair). Otherwise injury or damage may occur. DO NOT attempt any transfer without approval of the patient ' s physician, nurse or medical assistant. Thoroughly read the instructions in this Owner ' s Manual, observe a trained team of experts perform the lifting procedures and then perform the entire lift procedure several times with proper supervision and a capable individual acting as a patient. Use common sense in all lifts. Special care MUST BE taken with people with disabilities who cannot cooperate while being lifted.</p> <p>© 2011 Invacare Corporation. All rights reserved "</p>						

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G0144	<p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Based on clinical record review and interview, the agency failed to ensure the registered nurse coordinated with the aide providing services to ensure the patient was receiving appropriate care in 1 of 3 records reviewed of patients receiving home health aide only services with the potential to affect all patients receiving home health aide services. (3)</p> <p>Findings:</p> <p>1. Clinical record 3, start of care 10/31/2011, included plans of care for the certification periods 4/28/12 to 6/26/12 and 6/27/12 to 8/25/12 that evidenced the patient was receiving home health aide services. The record failed to evidence the registered nurse had made a supervisory nurse visit while the home health aide was in the home performing care to ensure the patient was receiving the required care. The record also failed to evidence the registered nurse was aware the patient was receiving wound care from the family member and the family member had instructed the aide not to wash the patient's feet.</p>	G0144	<ul style="list-style-type: none"> ·Patients, who do not receive skilled services but do receive Home Health Aide services, will be supervised by an RN every 30 days while the HHA is providing care. ·The DON will conduct case conference with the Home Health Aides at least monthly and document the meeting with dated minutes and attendance logs. ·In order to prevent reoccurrence, 100% review of all patient records where Home Health Aide services are being provided will be completed under the direction of the DON. ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012			

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	<p>2. Home health aide assignment sheet for the home health aide, signed by the registered nurse, Employee B, on 5/15/12 and 7/11/12, evidenced the aide was to clean, file and soak the patient's nails per the patient's request and to soak the feet per the patient's request. The record failed to evidence the registered nurse was aware the aide was not washing and soaking the patient's feet as assigned.</p> <p>3. On 8/21/12 at 11 AM, the Administrator indicated she did not think the aide had to be present for supervisory visits when the patient received home health aide only services. She thought it was an either/or situation.</p>			

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G0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record review and interview, the agency failed to ensure visits were made as ordered on the plan of care in 8 of 10 records reviewed with the potential to affect all 131 patients. (1, 2, 3, 4, 5, 7, 8 & 10)</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record 1, start of care (SOC) 2/10/12, with a certification period of 6/9/12 to 8/7/12, evidenced physician orders for Master of Social Work (MSW) and Skilled Nurse (SN) 1 time a week for 9 weeks. The clinical record failed to evidence a MSW and a SN visit was made week 1. Clinical record 2, SOC 10/23/09, with a certification period of 6/9/12 to 8/7/12, evidenced physician orders for home health aide (HHA) and SN one time a week for 9 weeks. The clinical record failed to evidence a SN and HHA visit was made week 1. Clinical record 3, SOC 10/31/11, with a certification period of 6/27/12 to 	G0158	<ul style="list-style-type: none"> ·Nursing and therapy staff will be educated regarding the plan of care, visit frequencies and duration. Specific deficiencies will be reviewed. ·The Plan of Care orders for frequency and duration shall be modified to include "beginning week of...." for all disciplines ordered, all patients. ·Orders will be written for additional visits and missed visit forms will be submitted to the primary physician. ·In order to prevent reoccurrence, schedules will be compared to all documentation submitted, a computerized missed visit report has been developed to report all visits scheduled but not made. ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012

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	<p>8/25/12, evidenced physician orders for HHA twice a day for 4 days a week for 9 weeks, HHA Respite one time a week for 9 weeks per VA authorization & patient request, and registered nurse (RN) to supervise and instruct HHAs one time a month for 2 months. The clinical record failed to evidence the HHA made 2 visits a day 4 days a week for week 1 and week 2.</p> <p>4. Clinical record 4, SOC 3/29/05, with a certification period of 6/20/12 to 8/18/12, evidenced physician orders for HHA 3-5 times a week for 9 weeks and SN 1 visit every 2 weeks for 9 weeks for skilled assessment and supervision. The clinical record failed to evidence at least 3 HHA visits were made week 3 and week 8. The clinical record failed to evidence a SN visit and supervisory visit of the HHA for week 8.</p> <p>5. Clinical record 5, SOC 3/26/12, with a certification period of 5/25/12 to 7/23/12, evidenced physician orders for HHA and Physical Therapy (PT) 1-2 times a week for 9 weeks and SN 1 time a week for 9 weeks. The clinical record failed to evidence a PT visit was made week 1. The clinical record failed to evidence a physician order for one extra HHA visit made week 2 and week 4. The clinical record failed to evidence a physician</p>			

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	<p>order for one extra SN visit made weeks 2 and 4.</p> <p>6. Clinical record 7, SOC 1/31/11, with a certification period of 5/25/12 to 7/23/12, evidenced physician orders for HHA 2-3 times a week for 9 weeks, MSW 1 time a week for 9 weeks, and Occupational Therapy (OT) 1-2 times a week for 6 months. The clinical record failed to evidence a HHA, MSW or OT visit was made week 1.</p> <p>7. Clinical record 8, SOC 4/12/12, with a certification period 6/11/12 to 8/9/12, evidenced physician orders for HHA 1-2 times a week for 9 weeks and MSW and SN 1 time a week for 9 weeks. The clinical record failed to evidence at least 1 HHA visit for week 7 and 9, a MSW visit for week 8 and 9, and a SN visit for week 9.</p> <p>8. Clinical record 10, SOC 9/13/11, with a certification period 1/11/12 to 3/10/12, evidenced physician orders for SN and MSW 1 time a week for 9 weeks and PT and OT 1-2 times a week for 9 weeks. The clinical record failed to evidence a SN visit for week 1.</p> <p>9. On August 16, 2012, at 10 AM, the Registered Nurse, Employee B, indicated she didn't realize the week started with</p>						

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G0170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record review and interview, the agency failed to ensure the skilled nurse made visits as ordered on the plan of care to provide skilled services in 6 of 10 records reviewed with the potential to affect all patients receiving skilled nurse services. (1, 2, 4, 5, 8 & 10)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 2/10/12, with a certification period of 6/9/12 to 8/7/12, evidenced physician orders for Skilled Nurse (SN) 1 time a week for 9 weeks. The clinical record failed to evidence a SN visit was made week 1.</p> <p>2. Clinical record 2, SOC 10/23/09, with a certification period of 6/9/12 to 8/7/12, evidenced physician orders for SN one time a week for 9 weeks. The clinical record failed to evidence a SN visit was made week 1.</p> <p>3. Clinical record 4, SOC 3/29/05, with a certification period of 6/20/12 to 8/18/12, evidenced physician orders for SN 1 visit every 2 weeks for 9 weeks for skilled assessment and supervision. The clinical record failed to evidence a SN visit and</p>	G0170	<ul style="list-style-type: none"> ·Nursing staff will be educated regarding the plan of care, visit frequencies and duration. Specific deficiencies will be reviewed. ·The Plan of Care orders for frequency and duration shall be modified to include "beginning week of..." for all disciplines ordered, all patients. ·Orders will be written for additional visits and missed visit forms will be submitted to the primary physician. ·In order to prevent reoccurrence, schedules will be compared to all documentation submitted, a computerized missed visit report has been developed to report all visits scheduled but not made. ·The Administrator is responsible to ensure the deficiency is corrected & maintain compliance 	09/20/2012			

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	<p>supervisory visit of the HHA for week 8.</p> <p>4. Clinical record 5, SOC 3/26/12, with a certification period of 5/25/12 to 7/23/12, evidenced physician orders for SN 1 time a week for 9 weeks. The clinical record failed to evidence a physician order for one extra SN visit made weeks 2 and 4.</p> <p>5. Clinical record 8, SOC 4/12/12, with a certification period 6/11/12 to 8/9/12, evidenced physician orders for SN 1 time a week for 9 weeks. The clinical record failed to evidence a SN visit for week 9.</p> <p>6. Clinical record 10, SOC 9/13/11, with a certification period 1/11/12 to 3/10/12, evidenced physician orders for SN 1 time a week for 9 weeks. The clinical record failed to evidence a SN visit for week 1.</p> <p>7. On August 16, 2012, at 10 AM, the Registered Nurse, Employee B, indicated she didn't realize the week started with the start of care date and not the Sunday through Saturday work week.</p>			

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G0172	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on clinical record review and interview, the agency failed to ensure the registered nurse provided a reassessment of needs in 1 of 1 records reviewed of patients with a VA payer source with the potential to effect all VA patients. (3).</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record 3, start of care 10/31/2011, included plans of care for the certification periods 4/28/12 to 6/26/12 and 6/27/12 to 8/25/12. The record failed to evidence the registered nurse had reassessed the patient's needs. On August 16, 2012, at 10 AM, the Registered Nurse, Employee B, indicated she was unaware the VA patients needed to be re-evaluated the same as Medicare patients. 	G0172	<ul style="list-style-type: none"> The registered nursing staff will be re-instructed in patient assessment requirements. The Comprehensive Assessment tool currently in use will be used to document all SOC & Recertification assessments. The OASIS responses are required for all patients receiving skilled services, over 18 years of age, who are not pregnant, and whose payers are Medicare, Medicare Advantage Plans, and Medicaid. The computer generated Expiring Certification report currently in use will be used to track assessments to prevent re-occurrence. The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012	

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G0176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse coordinated with the aide providing services to ensure the patient was receiving appropriate care in 1 of 3 records reviewed of patients receiving home health aide only services with the potential to affect all patients receiving home health aide services. (3)</p> <p>Findings:</p> <p>1. Clinical record 3, start of care 10/31/2011, included plans of care for the certification periods 4/28/12 to 6/26/12 and 6/27/12 to 8/25/12 that evidenced the patient was receiving home health aide services. The record failed to evidence the registered nurse had made a supervisory nurse visit while the home health aide was in the home performing care to ensure the patient was receiving the required care. The record also failed to evidence the registered nurse was aware the patient was receiving wound care from the family member and the family member had instructed the aide not</p>			G0176	<p>All nursing staff will receive in-service training regarding the POC and care coordination. Specific deficiencies will be reviewed. Instruction will include the regulatory requirement for communication with all disciplines. Communication regarding changes in patient status, orders, & coordination of services will be documented. Documentation reflecting this communication shall include visit notes, minutes of case conference and notations made to the supplemental information form contained in the file. The DON will see every patient admitted/recertified to identify potential problems with coordination of care and changes in patient condition.</p> <p>Each clinical record will be reviewed at least every 60 days to ensure reoccurrence does not occur.</p> <p>The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained.</p>		09/20/2012

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	<p>to wash the patient's feet.</p> <p>2. Home health aide assignment sheet for the home health aide, signed by the registered nurse, Employee B, on 5/15/12 and 7/11/12, evidenced the aide was to clean, file and soak the patient's nails per the patient's request and to soak the feet per the patient's request. The record failed to evidence the registered nurse was aware the aide was not washing and soaking the patient's feet as assigned.</p> <p>3. On 8/21/12 at 11 AM, the Administrator indicated she did not think the aide had to be present for supervisory visits when the patient received home health aide only services. She thought it was an either/or situation.</p>			

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G0184	<p>484.32 THERAPY SERVICES</p> <p>Based on observation, interview, and document review, it was determined the agency failed to ensure the occupational therapist advised the home health aides on the proper usage of a Hoyer in 1 of 1 home health aide visits observed of patients with a Hoyer with the potential to effect all patients with a Hoyer who receiving home health aide (HHA) services (See G 188) and failed to ensure the Occupational Therapist participated in an inservice for Hoyer use for 2 of 2 home health aides observed caring for a patient with a Hoyer with the potential to effect all patients with a Hoyer that received home health aide services (See G 189).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to provide safe patient care and being out of compliance with the Condition of Participation 484.32: Therapy Services.</p>			G0184	<ul style="list-style-type: none"> ·Home Health Aides will complete in-service training for special equipment (Hoyer Lift) from a qualified therapist. ·Home Health Aides will complete in-service training fro safe patient transfer techniques from a qualified therapist. ·The agency will obtain the operation manual for special equipment agency patients are using and incorporate its information in the in-service training material. ·In order to prevent reoccurrence, the DON will see every patient admitted/recertified who is receiving Home Health Aide services, to ensure the HHA assignment sheet is patient specific. She will verify the Home Health Aide assigned to the case has documented skill for that patient's needs. ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 		09/20/2012

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G0188	<p>484.32 THERAPY SERVICES The qualified therapist advises and consults with the family and other agency personnel. Based on observation, interview, and document review, the agency failed to ensure the occupational therapist advised the home health aides on the proper usage of a Hoyer in 1 of 1 home health aide visits observed of patients with a Hoyer with the potential to effect all patients with a Hoyer who receiving home health aide (HHA) services. (# 3)</p> <p>Findings:</p> <p>1. On August August 16, 2012, at 11:30 AM, Employee F and H, both HHAs, were at the home of patient # 3 to perform a bed bath and Hoyer transfer. The patient receives home health aide services only. The patient has a diagnosis of Late Effect Cardiovascular Accident. The senior aide, Employee H, prepared two tubs of water with two sets of washcloths and towels. She washed the face, upper torso, and legs of the patients. Without changing the water she washed the abdominal area, scrotal area, and then pulled back the foreskin and washed the penis. Employee F was helping with the rolling of the patient. The patient's feet were not washed as they were bloody and had bandages on them. After the patient was bathed and dressed, they prepared the</p>	G0188	<ul style="list-style-type: none"> ·Home Health Aides will complete in-service training for special equipment (Hoyer Lift) from a qualified therapist. ·Home Health Aides will complete in-service training fro safe patient transfer techniques from a qualified therapist. ·The agency will obtain the operation manual for special equipment agency patients are using and incorporate its information in the in-service training material. ·In order to prevent reoccurrence, the DON will see every patient admitted/recertified who is receiving Home Health Aide services, to ensure the HHA assignment sheet is patient specific. She will verify the Home Health Aide assigned to the case has documented skill for that patient's needs. ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012			

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	<p>patient for transfer to be up for the day. Employee F and H placed the Hoyer sling under the patient, placed the Hoyer legs under the bed (they did not open the Hoyer legs for stability), attached the rings of the sling to the cross arm of the Hoyer, and used the electronic controls to lift the patient. Employee H placed a pillow between the patient's knees and the upright bar of the Hoyer as to not bang the patient's knees and feet. She, walking backwards, guided the Invacare Reliant 450 Hoyer while Employee F stabilized the swinging patient from behind down the approximately 10 foot carpeted hallway and across the approximate 15 foot carpeted living room to the motorized chair. The patient was then successfully lowered into the chair and prepared for the day.</p> <p>2. n 8/20/12 at 10:30 AM, the Administrator indicated they did not have a manual for the Hoyer as the Hoyer was not provided by the agency. The HHAs, Employees F and H, had taken the written test for safety that had 3 questions about the Hoyer. She also indicated there was no documentation the HHAs had performed a competency for any Hoyer though it is customary for the Occupational Therapist to do so.</p> <p>3. The operation manual for the Invacare</p>						

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	<p>Reliant 450 (Hoyer) states, "2.2 Operating Information General</p> <p>WARNING DO NOT use this product or any available optional equipment without first completely reading and understanding these instructions and any additional instructional material such as owner ' s manuals, service manuals or instruction sheets supplied with this product or optional equipment. If you are unable to understand the warnings, cautions or instructions, contact a healthcare professional, dealer or technical personnel before attempting to use this equipment - otherwise, injury or damage may occur.</p> <p>ACCESSORIES WARNING Invacare products are specifically designed and manufactured for use in conjunction with Invacare accessories. Accessories designed by other manufacturers have not been tested by Invacare and are not recommended for use with Invacare products.</p> <p>! NOTICE THE INFORMATION CONTAINED IN THIS DOCUMENT IS SUBJECT TO CHANGE WITHOUT NOTICE.</p> <p>WARNING The Invacare patient lift is NOT a</p>			

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	<p>transport device. It is intended to transfer an individual from one resting surface to another (such as a bed to a wheelchair). Otherwise injury or damage may occur. DO NOT attempt any transfer without approval of the patient ' s physician, nurse or medical assistant. Thoroughly read the instructions in this Owner ' s Manual, observe a trained team of experts perform the lifting procedures and then perform the entire lift procedure several times with proper supervision and a capable individual acting as a patient. Use common sense in all lifts. Special care MUST BE taken with people with disabilities who cannot cooperate while being lifted.</p> <p>© 2011 Invacare Corporation. All rights reserved "</p>			

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G0189	<p>484.32 THERAPY SERVICES The qualified therapist participates in in-service programs.</p> <p>Based on inservices records and interview the agency failed to ensure the Occupational Therapist participated in an inservice for Hoyer use for 2 of 2 home health aides observed caring for a patient with a Hoyer with the potential to effect all patients with a Hoyer that received home health aide services. (F and H)</p> <p>Findings:</p> <ol style="list-style-type: none"> Inservice record F, date of hire (DOH) 6/1/12, failed to evidence the aide had training and a competency evaluation on use of a Hoyer lift. Inservice record H, DOH 1/4/12, failed to evidence the aide had training and a competency evaluation on use of a Hoyer lift. On 8/20/12 at 10:30 AM, the Administrator indicated the HHAs, Employee F and H, had taken the written test for safety that had 3 questions about the Hoyer. She also indicated there was no documentation the HHA's had performed a competency for any Hoyer though it is customary for the Occupational Therapist to do so with the 	G0189	<ul style="list-style-type: none"> Home Health Aides will complete in-service training for special equipment (Hoyer Lift) from a qualified therapist. Home Health Aides will complete in-service training for safe patient transfer techniques from a qualified therapist. The agency will obtain the operation manual for special equipment agency patients are using and incorporate its information in the in-service training material. In order to prevent reoccurrence, the DON will see every patient admitted/recertified who is receiving Home Health Aide services, to ensure the HHA assignment sheet is patient specific. She will verify the Home Health Aide assigned to the case has documented skill for that patient's needs. The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012			

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G0202	<p>484.36 HOME HEALTH AIDE SERVICES</p> <p>Based on personnel record, clinical record, and policy review; observation; and interview, the agency failed to ensure each home health aide had completed the competency evaluation requirements in CFR 484.36 (b)(1) before providing home health services for 3 of 20 home health aide files reviewed with the potential to effect all patients who receive home health aide services (See G 211 and G 212), failed to ensure the home health aide had a annual performance review by the registered nurse for 11 of 11 home health aides employed longer then 12 months with the potential to effect all patients who received home health aide services (See G 214), failed to ensure the home health aides completed 12 hours of inservice with 8 hours in the required categories for 6 of 12 home health aide files reviewed of aides employed 2 months in 2011 with the potential to effect all patients receiving home health aide services (See G 215), failed to ensure each home health aide had completed the competency evaluation requirements in CFR 484.36 (b)(1) by demonstrating the required skills on a patient or pseudo patient before providing home health services for 1 of 20 home health aide files reviewed with the potential to effect all patients who receive home health aide</p>	G0202	<ul style="list-style-type: none"> ·Patients who do not receive skilled services but do receive Home Health Aide services, will be supervised by an RN every 30 days while the HHA is providing care. ·The DON will immediately begin meeting every Home Health Aide in patient homes to observe the care provided, the performance of the Home Health Aide, and to identify the need for additional in-service training. ·This performance review will be conducted annually by the DON, documented, and filed in the employee file. ·Home Health Aides shall complete required annual in-service training: 12 hours with a minimum of 8 hours in any eight of the subject areas found in CFR 484.36 (a) and 410 IAC 17-14-1(h), or be subject to termination. ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012			

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	<p>services (See G 218), failed to ensure documentation evidenced each home health aide had completed the competency evaluation requirements in CFR 484.36 (b)(1) before providing home health services for 3 of 20 home health aide files reviewed with the potential to effect all patients who receive home health aide services (See G 221), failed to ensure each home health aide (HHA) was qualified to provide the care as required by CFR 484.36 (b)(1) for 3 of 20 home health aide files reviewed with the potential to effect all patients who receive home health aide services (See G 227), and failed to ensure the home health aide was present and providing care when supervisory visits were made by the registered nurse 1 of 2 records reviewed of patients receiving home health aide only services with the potential to effect all patients who receive home health aide services(See G 230).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to ensure home health aides were qualified and safe to provide services and to meet the requirements of the Condition of Participation 484.36: Home Health Aide Services.</p>			

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(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
G0211	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>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 personnel record, clinical record, and policy review; observation; and interview, the agency failed to ensure each home health aide (HHA) had completed the competency evaluation requirements in CFR 484.36 (b)(1) before providing home health services for 3 of 20 home health aide files reviewed with the potential to effect all patients who receive home health aide services. (F, H, and S)</p> <p>Findings:</p> <p>1. Personnel record F, date of hire (DOH) 6/1/12, failed to evidence competency evaluation in axillary and ear temperature, respiration, apical pulse, oral: gums, Bed bath: partial, Other bath: tub, Hair: wash-bed and wash-sink, Skin care: massage, Toileting: external catheter, Ambulation: crutches, and Patient Environment: assist with feeding. Additional Agency Requirements is blank as completed on 6/4/12 signed by Employee B, Registered Nurse. The form also failed to evidence the aide had been</p>	G0211	<ul style="list-style-type: none"> ·The DON will immediately begin meeting every Home Health Aide in patient homes to observe the care provided, the performance of the Home Health Aide, and to identify the need for additional in-service training. ·This performance review will be conducted annually by the DON, documented, and filed in the employee file. ·Home Health Aides shall complete required annual in-service training: 12 hours with a minimum of 8 hours in any eight of the subject areas found in CFR 484.36 (a) and 410 IAC 17-14-1(h), or be subject to termination. ·The Administrator will secure arrangements for future competency evaluations to be conducted by a qualified, disinterested, third party. ·The competency evaluations will meet regulatory requirements ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012			

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	<p>competency tested for a Hoyer lift.</p> <p>A. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Assignment Sheet" created 7/9/12 and signed 7/12/12 for patient 3 indicates the aide assignments are Oral: Gum Care Complete/Assist, Transfer: Hoyer Lift, Hair: Shampoo, Bed.</p> <p>B. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Visit Report" evidences on 6/29/12 the HHA, Employee F, transferred patient #3 by Hoyer.</p> <p>2. Personnel record H, DOH 1/4/12, failed to evidence competency evaluation in Additional Agency Requirement as blank completed 1/6/12 by registered nurse, Employee X. The form failed to evidence the aide had completed a competency for use of the Hoyer lift.</p> <p>A. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Assignment Sheet" created 7/9/12 and signed 7/12/12 for patient 3 indicates the aide assignment is Transfer: Hoyer Lift,</p> <p>B Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Visit Report" evidences on 6/27/12, 6/29/12, and 7/2/12 the HHA, Employee H,</p>			

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	<p>transferred the patient by Hoyer.</p> <p>3. A policy titled "Home Health Aide Competency Evaluation", 5/13/09, states, "Aides will be tested and/or observed in the following areas: ... 10. Safe transfer techniques and ambulation. ... 15 Items 9, 10, and 11 must be demonstrated on a patient or pseudo-patient. ... 16. Documentation of competency testing and evaluation will be maintained in the employee file."</p> <p>4. Personnel file S, DOH 6/26/12, failed to evidence a competency evaluation.</p> <p>A. Clinical record 11, start of care 4/19/2012, included a plan of care for the certification period 7/19/12 to 9/16/12 with orders for HHA 50 units a month prn (as needed) caregiver request, RN to supervise & instruct HHA.</p> <p>B. Clinical record 11 evidenced the HHA S provided care 7/19/12, 7/23/12, 7/26/12 and 7/30/12.</p> <p>5. On 8/20/12 at 10:30 AM, the Administrator indicated the HHAs, Employee F and H, had taken the written test for safety that had 3 questions about the Hoyer. She also indicated there was no documentation the HHAs had performed a competency for any Hoyer.</p>			

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	<p>6. On August August 16, 2012, at 11:30 AM, Employee F and H, both HHAs, were at the home of patient # 3 to perform a bed bath and Hoyer transfer. The patient receives home health aide services only. The patient has a diagnosis of Late Effect Cardiovascular Accident. The senior aide, Employee H, prepared two tubs of water with two sets of washcloths and towels. She washed the face, upper torso, and legs of the patients. Without changing the water she washed the abdominal area, scrotal area, and then pulled back the foreskin and washed the penis. Employee F was helping with the rolling of the patient. The patient's feet were not washed as they were bloody and had bandages on them. After the patient was bathed and dressed, they prepared the patient for transfer to be up for the day. Employee F and H placed the Hoyer sling under the patient, placed the Hoyer legs under the bed (they did not open the Hoyer legs for stability), attached the rings of the sling to the cross arm of the Hoyer, and used the electronic controls to lift the patient. Employee H placed a pillow between the patient's knees and the upright bar of the Hoyer as to not bang the patient's knees and feet. She, walking backwards, guided the Invacare Reliant 450 Hoyer while Employee F stabilized the swinging patient from behind down</p>				

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	the approximately 10 foot carpeted hallway and across the approximate 15 foot carpeted living room to the motorized chair. The patient was then successfully lowered into the chair and prepared for the day.			

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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 personnel record, clinical record, and policy review; observation; and interview, the agency failed to ensure each home health aide (HHA) had completed the competency evaluation requirements in CFR 484.36 (b)(1) before providing home health services for 3 of 20 home health aide files reviewed with the potential to effect all patients who receive home health aide services. (F, H, and S)</p> <p>Findings:</p> <p>1. Personnel record F, date of hire (DOH) 6/1/12, failed to evidence competency evaluation in axillary and ear temperature, respiration, apical pulse, oral: gums, Bed bath: partial, Other bath: tub, Hair: wash-bed and wash-sink, Skin care: massage, Toileting: external catheter, Ambulation: crutches, and Patient Environment: assist with feeding. Additional Agency Requirements is blank as completed on 6/4/12 signed by Employee B, Registered Nurse. The form</p>	G0212	<ul style="list-style-type: none"> ·The DON will immediately begin meeting every Home Health Aide in patient homes to observe the care provided, the performance of the Home Health Aide, and to identify the need for additional in-service training. ·This performance review will be conducted annually by the DON, documented, and filed in the employee file. ·Home Health Aides shall complete required annual in-service training: 12 hours with a minimum of 8 hours in any eight of the subject areas found in CFR 484.36 (a) and 410 IAC 17-14-1(h), or be subject to termination. ·The Administrator will secure arrangements for future competency evaluations to be conducted by a qualified, disinterested, third party. ·The competency evaluations will meet regulatory requirements ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012	

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	<p>also failed to evidence the aide had been competency tested for a Hoyer lift.</p> <p>A. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Assignment Sheet" created 7/9/12 and signed 7/12/12 for patient 3 indicates the aide assignments are Oral: Gum Care Complete/Assist, Transfer: Hoyer Lift, Hair: Shampoo, Bed.</p> <p>B. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Visit Report" evidences on 6/29/12 the HHA, Employee F, transferred patient #3 by Hoyer.</p> <p>2. Personnel record H, DOH 1/4/12, failed to evidence competency evaluation in Additional Agency Requirement as blank completed 1/6/12 by registered nurse, Employee X. The form failed to evidence the aide had completed a competency for use of the Hoyer lift.</p> <p>A. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Assignment Sheet" created 7/9/12 and signed 7/12/12 for patient 3 indicates the aide assignment is Transfer: Hoyer Lift,</p> <p>B Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Visit Report" evidences on 6/27/12, 6/29/12,</p>						

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	<p>and 7/2/12 the HHA, Employee H, transferred the patient by Hoyer.</p> <p>3. A policy titled 'Home Health Aide Competency Evaluation', 5/13/09, states, "Aides will be tested and/or observed in the following areas: ... 10. Safe transfer techniques and ambulation. ... 15 Items 9, 10, and 11 must be demonstrated on a patient or pseudo-patient. ... 16. Documentation of competency testing and evaluation will be maintained in the employee file."</p> <p>4. Personnel file S, DOH 6/26/12, failed to evidence a competency evaluation.</p> <p>A. Clinical record 11, start of care 4/19/2012, included a plan of care for the certification period 7/19/12 to 9/16/12 with orders for HHA 50 units a month prn (as needed) caregiver request, RN to supervise & instruct HHA.</p> <p>B. Clinical record 11 evidenced the HHA S provided care 7/19/12, 7/23/12, 7/26/12 and 7/30/12.</p> <p>5. On 8/20/12 at 10:30 AM, the Administrator indicated the HHAs, Employee F and H, had taken the written test for safety that had 3 questions about the Hoyer. She also indicated there was no documentation the HHAs had</p>						

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	<p>performed a competency for any Hoyer.</p> <p>6. On August August 16, 2012, at 11:30 AM, Employee F and H, both HHAs, were at the home of patient # 3 to perform a bed bath and Hoyer transfer. The patient receives home health aide services only. The patient has a diagnosis of Late Effect Cardiovascular Accident. The senior aide, Employee H, prepared two tubs of water with two sets of washcloths and towels. She washed the face, upper torso, and legs of the patients. Without changing the water she washed the abdominal area, scrotal area, and then pulled back the foreskin and washed the penis. Employee F was helping with the rolling of the patient. The patient's feet were not washed as they were bloody and had bandages on them. After the patient was bathed and dressed, they prepared the patient for transfer to be up for the day. Employee F and H placed the Hoyer sling under the patient, placed the Hoyer legs under the bed (they did not open the Hoyer legs for stability), attached the rings of the sling to the cross arm of the Hoyer, and used the electronic controls to lift the patient. Employee H placed a pillow between the patient's knees and the upright bar of the Hoyer as to not bang the patient's knees and feet. She, walking backwards, guided the Invacare Reliant 450 Hoyer while Employee F stabilized</p>			

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	the swinging patient from behind down the approximately 10 foot carpeted hallway and across the approximate 15 foot carpeted living room to the motorized chair. The patient was then successfully lowered into the chair and prepared for the day.			

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G0214	<p>484.36(b)(2)(ii) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The HHA must complete a performance review of each home health aide no less frequently than every 12 months. Based on personnel file and agency document review and interview, the agency failed to ensure the home health aide had a annual performance review by the registered nurse for 11 of 11 home health aides employed longer then 12 months with the potential to effect all patients who received home health aide services. (D, E, I, J, K, M, N, P, Q, U and V)</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A agency document titled "Daybreak & Visiting Nurse Care, LLC Performance Appraisal & Development Plan" failed to evidence the registered nurse could evaluate the home health aides. 2. Personnel records D, E, I, J, K, M, N, P, Q, U, and V all evidenced completed "Daybreak & Visiting Nurse Care, LLC Performance Appraisal & Development Plan" completed, signed, and dated by the Administrator, Employee A. 3. On 8/21/12 at 11 AM, the Administrator, Employee A, indicated she completed the Performance Appraisals for 	G0214	<ul style="list-style-type: none"> ·The DON will immediately begin meeting every Home Health Aide in patient homes to observe the care provided, the performance of the Home Health Aide, and to identify the need for additional in-service training. ·This performance review will be conducted annually by the DON, documented, and filed in the employee file. ·Home Health Aides shall complete required annual in-service training: 12 hours with a minimum of 8 hours in any eight of the subject areas found in CFR 484.36 (a) and 410 IAC 17-14-1(h), or be subject to termination. ·The Administrator will secure arrangements for future competency evaluations to be conducted by a qualified, disinterested, third party. ·The competency evaluations will meet regulatory requirements ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012			

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	all employees, and, though she asks for input, there is no documentation of such. She is not a registered nurse.			

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G0215	<p>484.36(b)(2)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI The home health aide must receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient.</p> <p>Based on inservice record and policy review and interview, the agency failed to ensure the home health aides completed 12 hours of inservice with 8 hours in the required categories for 6 of 12 home health aide files reviewed of aides employed 12 months in 2011 with the potential to effect all patients receiving home health aide services. (E, I, M, N, U, and V)</p> <p>Findings:</p> <p>1. Inservice record E, date of hire (DOH) 1/28/11, failed to evidence a total at least twelve (12) hours from January 1 through December 31, 2011, inclusive, with a minimum of eight (8) hours in any eight (8) subject areas found in CFR 484.36 (a) (1).</p> <p>2. Inservice record I, DOH 11/12/03, failed to evidence a total at least twelve (12) hours from January 1 through December 31, 2011, inclusive, with a</p>	G0215	<ul style="list-style-type: none"> ·The DON will immediately begin meeting every Home Health Aide in patient homes to observe the care provided, the performance of the Home Health Aide, and to identify the need for additional in-service training. ·This performance review will be conducted annually by the DON, documented, and filed in the employee file. ·Home Health Aides shall complete required annual in-service training: 12 hours with a minimum of 8 hours in any eight of the subject areas found in CFR 484.36 (a) and 410 IAC 17-14-1(h), or be subject to termination. ·The Administrator will secure arrangements for future competency evaluations to be conducted by a qualified, disinterested, third party. ·The competency evaluations will meet regulatory requirements ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012			

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	<p>minimum of eight (8) hours in any eight (8) subject areas found in CFR 484.36 (a) (1).</p> <p>3. Inservice record M, DOH 5/1/98, failed to evidence a total at least twelve (12) hours from January 1 through December 31, 2011, inclusive, with a minimum of eight (8) hours in any eight (8) subject areas found in CFR 484.36 (a) (1).</p> <p>4. Inservice record N, DOH 1/4/99, failed to evidence a total at least twelve (12) hours from January 1 through December 31, 2011, inclusive, with a minimum of eight (8) hours in any eight (8) subject areas found in CFR 484.36 (a) (1).</p> <p>5. Inservice record U, DOH 10/29/08, failed to evidence a total at least twelve (12) hours from January 1 through December 31, 2011, inclusive, with a minimum of eight (8) hours in any eight (8) subject areas found in CFR 484.36 (a) (1).</p> <p>6. Inservice record V, DOH 1/25/00, failed to evidence a total at least twelve (12) hours from January 1 through December 31, 2011, inclusive, with a minimum of eight (8) hours in any eight (8) subject areas found in CFR 484.36 (a) (1).</p>			

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	<p>7. On August 21, 2012, at 11 AM, the Administrator, Employee A, indicated the inservices are set but the documentation has not been monitored to make sure the aides are completing inservices required.</p> <p>8. A policy titled "Home Aide Competency Evaluation and Inservice Training", 5/13/09, states, "Current Employees: 1. Annually (January through December) Home Health Aides are required to complete twelve (12) hours of continuing education, with a minimum of eight (8) hours in any eight (8) of the subject areas listed in 410 IAC 17-14-1 Sec. 1 (h) & Federal COP 484.36 (a). The continuing education must be performed by or under the general supervision of a registered nurse."</p>			

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NAME OF PROVIDER OR SUPPLIER DAYBREAK & VISITING NURSE CARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1304 MAIN ST ANDERSON, IN 46016			
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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 personnel record, clinical record, and policy review, the agency failed to ensure each home health aide (HHA) had completed the competency evaluation requirements in CFR 484.36 (b)(1) by demonstrating the required skills on a patient or pseudo patient before providing home health services for 1 of 20 home health aide files reviewed with the potential to effect all patients who receive home health aide services. (S)</p> <p>Findings:</p> <p>1. A policy titled "Home Health Aide Competency Evaluation", 5/13/09, states, "Aides will be tested and/or observed in the following areas: ... 10. Safe transfer techniques and ambulation. ... 15 Items 9, 10, and 11 must be demonstrated on a patient or pseudo-patient. ... 16. Documentation of competency testing and evaluation will be maintained in the</p>	G0218	<ul style="list-style-type: none"> ·The DON will immediately begin meeting every Home Health Aide in patient homes to observe the care provided, the performance of the Home Health Aide, and to identify the need for additional in-service training. ·This performance review will be conducted annually by the DON, documented, and filed in the employee file. ·Home Health Aides shall complete required annual in-service training: 12 hours with a minimum of 8 hours in any eight of the subject areas found in CFR 484.36 (a) and 410 IAC 17-14-1(h), or be subject to termination. ·The Administrator will secure arrangements for future competency evaluations to be conducted by a qualified, disinterested, third party. ·The competency evaluations will meet regulatory requirements ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012			

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	<p>employee file."</p> <p>2. Personnel file S, DOH 6/26/12, failed to evidence a competency evaluation.</p> <p>A. Clinical record 11, start of care 4/19/2012, included a plan of care for the certification period 7/19/12 to 9/16/12 with orders for HHA 50 units a month prn (as needed) caregiver request, RN to supervise & instruct HHA.</p> <p>B. Clinical record 11 evidenced the HHA S provided care 7/19/12, 7/23/12, 7/26/12 and 7/30/12.</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 personnel record, clinical record, and policy review; observation; and interview, the agency failed to ensure documentation evidenced each home health aide (HHA) had completed the competency evaluation requirements in CFR 484.36 (b)(1) before providing home health services for 3 of 20 home health aide files reviewed with the potential to effect all patients who receive home health aide services. (F, H, and S)</p> <p>Findings:</p> <p>1. Personnel record F, date of hire (DOH) 6/1/12, failed to evidence competency evaluation in axillary and ear temperature, respiration, apical pulse, oral: gums, Bed bath: partial, Other bath: tub, Hair: wash-bed and wash-sink, Skin care: massage, Toileting: external catheter, Ambulation: crutches, and Patient Environment: assist with feeding. Additional Agency Requirements is blank as completed on 6/4/12 signed by Employee B, Registered Nurse. The form also failed to evidence the aide had been competency tested for a Hoyer lift.</p>	G0221	<ul style="list-style-type: none"> ·The DON will immediately begin meeting every Home Health Aide in patient homes to observe the care provided, the performance of the Home Health Aide, and to identify the need for additional in-service training. ·This performance review will be conducted annually by the DON, documented, and filed in the employee file. ·Home Health Aides shall complete required annual in-service training: 12 hours with a minimum of 8 hours in any eight of the subject areas found in CFR 484.36 (a) and 410 IAC 17-14-1(h), or be subject to termination. ·The Administrator will secure arrangements for future competency evaluations to be conducted by a qualified, disinterested, third party. ·The competency evaluations will meet regulatory requirements ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012			

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	<p>A. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Assignment Sheet" created 7/9/12 and signed 7/12/12 for patient 3 indicates the aide assignments are Oral: Gum Care Complete/Assist, Transfer: Hoyer Lift, Hair: Shampoo, Bed.</p> <p>B. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Visit Report" evidences on 6/29/12 the HHA, Employee F, transferred patient #3 by Hoyer.</p> <p>2. Personnel record H, DOH 1/4/12, failed to evidence competency evaluation in Additional Agency Requirement as blank completed 1/6/12 by registered nurse, Employee X. The form failed to evidence the aide had completed a competency for use of the Hoyer lift.</p> <p>A. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Assignment Sheet" created 7/9/12 and signed 7/12/12 for patient 3 indicates the aide assignment is Transfer: Hoyer Lift,</p> <p>B Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Visit Report" evidences on 6/27/12, 6/29/12, and 7/2/12 the HHA, Employee H, transferred the patient by Hoyer.</p>			

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	<p>3. A policy titled "Home Health Aide Competency Evaluation", 5/13/09, states, "Aides will be tested and/or observed in the following areas: ... 10. Safe transfer techniques and ambulation. ... 15 Items 9, 10, and 11 must be demonstrated on a patient or pseudo-patient. ... 16. Documentation of competency testing and evaluation will be maintained in the employee file."</p> <p>4. Personnel file S, DOH 6/26/12, failed to evidence a competency evaluation.</p> <p>A. Clinical record 11, start of care 4/19/2012, included a plan of care for the certification period 7/19/12 to 9/16/12 with orders for HHA 50 units a month prn (as needed) caregiver request, RN to supervise & instruct HHA.</p> <p>B. Clinical record 11 evidenced the HHA S provided care 7/19/12, 7/23/12, 7/26/12 and 7/30/12.</p> <p>5. On 8/20/12 at 10:30 AM, the Administrator indicated the HHAs, Employee F and H, had taken the written test for safety that had 3 questions about the Hoyer. She also indicated there was no documentation the HHAs had performed a competency for any Hoyer.</p>			

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	<p>6. On August August 16, 2012, at 11:30 AM, Employee F and H, both HHAs, were at the home of patient # 3 to perform a bed bath and Hoyer transfer. The patient receives home health aide services only. The patient has a diagnosis of Late Effect Cardiovascular Accident. The senior aide, Employee H, prepared two tubs of water with two sets of washcloths and towels. She washed the face, upper torso, and legs of the patients. Without changing the water she washed the abdominal area, scrotal area, and then pulled back the foreskin and washed the penis. Employee F was helping with the rolling of the patient. The patient's feet were not washed as they were bloody and had bandages on them. After the patient was bathed and dressed, they prepared the patient for transfer to be up for the day. Employee F and H placed the Hoyer sling under the patient, placed the Hoyer legs under the bed (they did not open the Hoyer legs for stability), attached the rings of the sling to the cross arm of the Hoyer, and used the electronic controls to lift the patient. Employee H placed a pillow between the patient's knees and the upright bar of the Hoyer as to not bang the patient's knees and feet. She, walking backwards, guided the Invacare Reliant 450 Hoyer while Employee F stabilized the swinging patient from behind down the approximately 10 foot carpeted</p>			
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	hallway and across the approximate 15 foot carpeted living room to the motorized chair. The patient was then successfully lowered into the chair and prepared for the day.			

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G0227	<p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Any home health aide services offered by an HHA must be provided by a qualified home health aide.</p> <p>Based on personnel record, clinical record, and policy review; observation; and interview, the agency failed to ensure each home health aide (HHA) was qualified to provide the care as required by CFR 484.36 (b)(1) for 3 of 20 home health aide files reviewed with the potential to effect all patients who receive home health aide services. (F, H, and S)</p> <p>Findings:</p> <p>1. Personnel record F, date of hire (DOH) 6/1/12, failed to evidence competency evaluation in axillary and ear temperature, respiration, apical pulse, oral: gums, Bed bath: partial, Other bath: tub, Hair: wash-bed and wash-sink, Skin care: massage, Toileting: external catheter, Ambulation: crutches, and Patient Environment: assist with feeding. Additional Agency Requirements is blank as completed on 6/4/12 signed by Employee B, Registered Nurse. The form also failed to evidence the aide had been competency tested for a Hoyer lift.</p> <p>A. Form titled "Daybreak & Visiting</p>	G0227	<ul style="list-style-type: none"> ·The DON will immediately begin meeting every Home Health Aide in patient homes to observe the care provided, the performance of the Home Health Aide, and to identify the need for additional in-service training. ·This performance review will be conducted annually by the DON, documented, and filed in the employee file. ·Home Health Aides shall complete required annual in-service training: 12 hours with a minimum of 8 hours in any eight of the subject areas found in CFR 484.36 (a) and 410 IAC 17-14-1(h), or be subject to termination. ·The Administrator will secure arrangements for future competency evaluations to be conducted by a qualified, disinterested, third party. ·The competency evaluations will meet regulatory requirements ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012			

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	<p>Nurse Care, LLC Home Health Aide Assignment Sheet" created 7/9/12 and signed 7/12/12 for patient 3 indicates the aide assignments are Oral: Gum Care Complete/Assist, Transfer: Hoyer Lift, Hair: Shampoo, Bed.</p> <p>B. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Visit Report" evidences on 6/29/12 the HHA, Employee F, transferred patient #3 by Hoyer.</p> <p>2. Personnel record H, DOH 1/4/12, failed to evidence competency evaluation in Additional Agency Requirement as blank completed 1/6/12 by registered nurse, Employee X. The form failed to evidence the aide had completed a competency for use of the Hoyer lift.</p> <p>A. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Assignment Sheet"created 7/9/12 and signed 7/12/12 for patient 3 indicates the aide assignment is Transfer: Hoyer Lift,</p> <p>B Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Visit Report" evidences on 6/27/12, 6/29/12, and 7/2/12 the HHA, Employee H, transferred the patient by Hoyer.</p> <p>3. A policy titled 'Home Health Aide</p>						

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	<p>Competency Evaluation", 5/13/09, states, "Aides will be tested and/or observed in the following areas: ... 10. Safe transfer techniques and ambulation. ... 15 Items 9, 10, and 11 must be demonstrated on a patient or pseudo-patient. ... 16. Documentation of competency testing and evaluation will be maintained in the employee file."</p> <p>4. Personnel file S, DOH 6/26/12, failed to evidence a competency evaluation.</p> <p>A. Clinical record 11, start of care 4/19/2012, included a plan of care for the certification period 7/19/12 to 9/16/12 with orders for HHA 50 units a month prn (as needed) caregiver request, RN to supervise & instruct HHA.</p> <p>B. Clinical record 11 evidenced the HHA S provided care 7/19/12, 7/23/12, 7/26/12 and 7/30/12.</p> <p>5. On 8/20/12 at 10:30 AM, the Administrator indicated the HHAs, Employee F and H, had taken the written test for safety that had 3 questions about the Hoyer. She also indicated there was no documentation the HHAs had performed a competency for any Hoyer.</p> <p>6. On August August 16, 2012, at 11:30 AM, Employee F and H, both HHAs,</p>						

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	were at the home of patient # 3 to perform a bed bath and Hoyer transfer. The patient receives home health aide services only. The patient has a diagnosis of Late Effect Cardiovascular Accident. The senior aide, Employee H, prepared two tubs of water with two sets of washcloths and towels. She washed the face, upper torso, and legs of the patients. Without changing the water she washed the abdominal area, scrotal area, and then pulled back the foreskin and washed the penis. Employee F was helping with the rolling of the patient. The patient's feet were not washed as they were bloody and had bandages on them. After the patient was bathed and dressed, they prepared the patient for transfer to be up for the day. Employee F and H placed the Hoyer sling under the patient, placed the Hoyer legs under the bed (they did not open the Hoyer legs for stability), attached the rings of the sling to the cross arm of the Hoyer, and used the electronic controls to lift the patient. Employee H placed a pillow between the patient's knees and the upright bar of the Hoyer as to not bang the patient's knees and feet. She, walking backwards, guided the Invacare Reliant 450 Hoyer while Employee F stabilized the swinging patient from behind down the approximately 10 foot carpeted hallway and across the approximate 15 foot carpeted living room to the			

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	motorized chair. The patient was then successfully lowered into the chair and prepared for the day.			

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G0230	<p>484.36(d)(3) SUPERVISION</p> <p>If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 62 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the home health aide was present and providing care when supervisory visits were made by the registered nurse 1 of 2 records reviewed of patients receiving home health aide only services with the potential to effect all patients who receive home health aide services.</p> <p>(H)</p> <p>Findings:</p> <p>1. Clinical record 3, start of care 10/31/2011, included plans of care for the certification periods 4/28/12 to 6/26/12 and 6/27/12 to 8/25/12 that evidenced the patient was receiving home health aide services. The record failed to evidence the registered nurse had made a supervisory nurse visit while the home health aide was in the home performing care to ensure the patient was receiving</p>	G0230	<ul style="list-style-type: none"> ·Patients, who do not receive skilled services but do receive Home Health Aide services, will be supervised by an RN every 30 days while the HHA is providing care. ·The DON will conduct case conference with the Home Health Aides at monthly and document the meeting with dated minutes and attendance logs. ·In order to prevent reoccurrence, 100% review of all patient records where Home Health Aide services are being provided will be completed under the direction of the DON. ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012	

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	<p>the required care.</p> <p>2. Home health aide assignment sheet for the home health aide, signed by the registered nurse, Employee B, on 5/15/12 and 7/11/12, evidenced the aide was to clean, file and soak the patient's nails per the patient's request and to soak the feet per the patient's request. The record failed to evidence the registered nurse was aware the aide was not washing and soaking the patient's feet as assigned.</p> <p>3. On 8/21/12 at 11 AM, the Administrator indicated she did not think the aide had to be present for supervisory visits when the patient received home health aide only services. She thought it was an either/or situation.</p> <p>4. On 8/20/12 at 11:15 AM, Employee H, the home health aide, indicated she had not been present when the nurse made the supervisory visit.</p> <p>5. A policy titled "Home Health Aide Supervision", 4.11.1, Revised 2009, states, "Each of these supervisory visits must occur while the Home Health Aide is providing care to the patient."</p>				

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(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0339	<p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. Based on clinical record review and interview, the agency failed to ensure all patients had a comprehensive reassessment every 60 days in 1 of 1 record reviewed of patients with a VA payer source with the potential to affect all patients with a VA payer source. (3).</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record 3, start of care 10/31/2011, included plans of care for the certification periods 4/28/12 to 6/26/12 and 6/27/12 to 8/25/12. The record failed to evidence the registered nurse had reassessed the patient's needs. On August 16, 2012, at 10 AM, the Registered Nurse, Employee B, indicated she was unaware the VA patients needed to be re-evaluated the same as Medicare patients. 	G0339	<ul style="list-style-type: none"> The registered nursing staff will be re-instructed in patient assessment requirements. The Comprehensive Assessment tool currently in use will be used to document all SOC & Recertification assessments. The OASIS responses are required for all patients receiving skilled services, over 18 years of age, who are not pregnant, and whose payers are Medicare, Medicare Advantage Plans, and Medicaid. The computer generated Expiring Certification report currently in use will be used to track assessments to prevent re-occurrence. The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012	

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N0484	<p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse coordinated with the aide providing services to ensure the patient was receiving appropriate care in 1 of 3 records reviewed of patients receiving home health aide only services with the potential to affect all patients receiving home health aide services. (3)</p> <p>Findings:</p> <p>1. Clinical record 3, start of care 10/31/2011, included plans of care for the certification periods 4/28/12 to 6/26/12 and 6/27/12 to 8/25/12 that evidenced the patient was receiving home health aide services. The record failed to evidence the registered nurse had made a supervisory nurse visit while the home health aide was in the home performing care to ensure the patient was receiving the required care. The record also failed to evidence the registered nurse was aware the patient was receiving wound care from the family member and the</p>	N0484	<p>·All nursing staff will receive in-service training regarding the POC and care coordination. Specific deficiencies will be reviewed. Instruction will include the regulatory requirement for communication with all disciplines. Communication regarding changes in patient status, orders, & coordination of services will be documented. Documentation reflecting this communication shall include visit notes, minutes of case conference and notations made to the supplemental information form contained in the file. The DON will see every patient admitted/recertified to identify potential problems with coordination of care and changes in patient condition.</p> <p>·Each clinical record will be reviewed at least every 60 days to ensure reoccurrence does not occur.</p> <p>·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained.</p>	09/20/2012			

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	<p>family member had instructed the aide not to wash the patient's feet.</p> <p>2. Home health aide assignment sheet for the home health aide, signed by the registered nurse, Employee B, on 5/15/12 and 7/11/12, evidenced the aide was to clean, file and soak the patient's nails per the patient's request and to soak the feet per the patient's request. The record failed to evidence the registered nurse was aware the aide was not washing and soaking the patient's feet as assigned.</p> <p>3. On 8/21/12 at 11 AM, the Administrator indicated she did not think the aide had to be present for supervisory visits when the patient received home health aide only services. She thought it was an either/or situation.</p>			

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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review and interview, the agency failed to ensure visits were made as ordered on the plan of care in 8 of 10 records reviewed with the potential to affect all 131 patients. (1, 2, 3, 4, 5, 7, 8 & 10)</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record 1, start of care (SOC) 2/10/12, with a certification period of 6/9/12 to 8/7/12, evidenced physician orders for Master of Social Work (MSW) and Skilled Nurse (SN) 1 time a week for 9 weeks. The clinical record failed to evidence a MSW and a SN visit was made week 1. Clinical record 2, SOC 10/23/09, with a certification period of 6/9/12 to 8/7/12, evidenced physician orders for home health aide (HHA) and SN one time a week for 9 weeks. The clinical record failed to evidence a SN and HHA visit was made week 1. Clinical record 3, SOC 10/31/11, with a certification period of 6/27/12 to 	N0522	<ul style="list-style-type: none"> ·Nursing and therapy staff will be educated regarding the plan of care, visit frequencies and duration. Specific deficiencies will be reviewed. ·The Plan of Care orders for frequency and duration shall be modified to include "beginning week of...." for all disciplines ordered, all patients. ·Orders will be written for additional visits and missed visit forms will be submitted to the primary physician. ·In order to prevent reoccurrence, schedules will be compared to all documentation submitted, a computerized missed visit report has been developed to report all visits scheduled but not made. ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012

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	<p>8/25/12, evidenced physician orders for HHA twice a day for 4 days a week for 9 weeks, HHA Respite one time a week for 9 weeks per VA authorization & patient request, and registered nurse (RN) to supervise and instruct HHAs one time a month for 2 months. The clinical record failed to evidence the HHA made 2 visits a day 4 days a week for week 1 and week 2.</p> <p>4. Clinical record 4, SOC 3/29/05, with a certification period of 6/20/12 to 8/18/12, evidenced physician orders for HHA 3-5 times a week for 9 weeks and SN 1 visit every 2 weeks for 9 weeks for skilled assessment and supervision. The clinical record failed to evidence at least 3 HHA visits were made week 3 and week 8. The clinical record failed to evidence a SN visit and supervisory visit of the HHA for week 8.</p> <p>5. Clinical record 5, SOC 3/26/12, with a certification period of 5/25/12 to 7/23/12, evidenced physician orders for HHA and Physical Therapy (PT) 1-2 times a week for 9 weeks and SN 1 time a week for 9 weeks. The clinical record failed to evidence a PT visit was made week 1. The clinical record failed to evidence a physician order for one extra HHA visit made week 2 and week 4. The clinical record failed to evidence a physician</p>						

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	<p>order for one extra SN visit made weeks 2 and 4.</p> <p>6. Clinical record 7, SOC 1/31/11, with a certification period of 5/25/12 to 7/23/12, evidenced physician orders for HHA 2-3 times a week for 9 weeks, MSW 1 time a week for 9 weeks, and Occupational Therapy (OT) 1-2 times a week for 6 months. The clinical record failed to evidence a HHA, MSW or OT visit was made week 1.</p> <p>7. Clinical record 8, SOC 4/12/12, with a certification period 6/11/12 to 8/9/12, evidenced physician orders for HHA 1-2 times a week for 9 weeks and MSW and SN 1 time a week for 9 weeks. The clinical record failed to evidence at least 1 HHA visit for week 7 and 9, a MSW visit for week 8 and 9, and a SN visit for week 9.</p> <p>8. Clinical record 10, SOC 9/13/11, with a certification period 1/11/12 to 3/10/12, evidenced physician orders for SN and MSW 1 time a week for 9 weeks and PT and OT 1-2 times a week for 9 weeks. The clinical record failed to evidence a SN visit for week 1.</p> <p>9. On August 16, 2012, at 10 AM, the Registered Nurse, Employee B, indicated she didn't realize the week started with</p>						

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	the start of care date and not the Sunday through Saturday work week.			

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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 clinical record and interview the agency failed to ensure the Occupational Therapist (OT) orders included the correct duration of 9 weeks when the care was being provided in 2 of 2 OT charts reviewed with the potential to effect all patients receiving OT services. (6 & 7)</p> <p>Findings:</p> <p>1. Clinical record 6, SOC 3/8/12, included a plan of care for the</p>	N0524	<p>·Therapy staff will be re-educated regarding the visit duration requirements for the POC. Specific deficiencies will be reviewed. ·Each clinical record will be reviewed at least every 60 days to ensure reoccurrence does not occur. ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained.</p>	09/20/2012			

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	<p>certification period of 5/7/12 to 7/5/12 with OT orders 1-2 times a week for 12 weeks.</p> <p>2. Clinical record 7, SOC 1/31/11, included a plan of care for the certification period of 5/25/12 to 7/23/12 with OT orders 1-2 times a week for 6 months.</p> <p>3. On August 16, 2012 at 10 AM, the Registered Nurse, Employee B, indicated orders should be written for the certification period care is being given in.</p>			

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N0537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record review and interview the agency failed to ensure care was Based on clinical record review and interview, the agency failed to ensure the skilled nurse made visits as ordered on the plan of care to provide skilled services in 6 of 10 records reviewed with the potential to affect all patients receiving skilled nurse services. (1, 2, 4, 5, 8 & 10)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 2/10/12, with a certification period of 6/9/12 to 8/7/12, evidenced physician orders for Skilled Nurse (SN) 1 time a week for 9 weeks. The clinical record failed to evidence a SN visit was made week 1.</p> <p>2. Clinical record 2, SOC 10/23/09, with a certification period of 6/9/12 to 8/7/12, evidenced physician orders for SN one time a week for 9 weeks. The clinical record failed to evidence a SN visit was made week 1.</p> <p>3. Clinical record 4, SOC 3/29/05, with a</p>	N0537	<ul style="list-style-type: none"> ·Nursing staff will be educated regarding the plan of care, visit frequencies and duration. Specific deficiencies will be reviewed. ·The Plan of Care orders for frequency and duration shall be modified to include "beginning week of...." for all disciplines ordered, all patients. ·Orders will be written for additional visits and missed visit forms will be submitted to the primary physician. ·In order to prevent reoccurrence, schedules will be compared to all documentation submitted, a computerized missed visit report has been developed to report all visits scheduled but not made. ·The Administrator is responsible to ensure the deficiency is corrected & maintain compliance 	09/20/2012			

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	<p>certification period of 6/20/12 to 8/18/12, evidenced physician orders for SN 1 visit every 2 weeks for 9 weeks for skilled assessment and supervision. The clinical record failed to evidence a SN visit and supervisory visit of the HHA for week 8.</p> <p>4. Clinical record 5, SOC 3/26/12, with a certification period of 5/25/12 to 7/23/12, evidenced physician orders for SN 1 time a week for 9 weeks. The clinical record failed to evidence a physician order for one extra SN visit made weeks 2 and 4.</p> <p>5. Clinical record 8, SOC 4/12/12, with a certification period 6/11/12 to 8/9/12, evidenced physician orders for SN 1 time a week for 9 weeks. The clinical record failed to evidence a SN visit for week 9.</p> <p>6. Clinical record 10, SOC 9/13/11, with a certification period 1/11/12 to 3/10/12, evidenced physician orders for SN 1 time a week for 9 weeks. The clinical record failed to evidence a SN visit for week 1.</p> <p>7. On August 16, 2012, at 10 AM, the Registered Nurse, Employee B, indicated she didn't realize the week started with the start of care date and not the Sunday through Saturday work week.</p>			

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N0541	<p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on clinical record review and interview, the agency failed to ensure the registered nurse provided a reassessment of needs in 1 of 1 records reviewed of patients with a VA payer source with the potential to effect all VA patients. (3).</p> <p>Findings:</p> <p>1. Clinical record 3, start of care 10/31/2011, included plans of care for the certification periods 4/28/12 to 6/26/12 and 6/27/12 to 8/25/12. The record failed to evidence the registered nurse had reassessed the patient's needs.</p> <p>2. On August 16, 2012, at 10 AM, the Registered Nurse, Employee B, indicated she was unaware the VA patients needed to be re-evaluated the same as Medicare patients.</p>	N0541	<ul style="list-style-type: none"> ·The registered nursing staff will be re-instructed in patient assessment requirements. ·The Comprehensive Assessment tool currently in use will be used to document all SOC & Recertification assessments. ·The OASIS responses are required for all patients receiving skilled services, over 18 years of age, who are not pregnant, and whose payers are Medicare, Medicare Advantage Plans, and Medicaid. ·The computer generated Expiring Certification report currently in use will be used to track assessments to prevent re-occurrence. ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012	

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N0545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on clinical record review and interview, the agency failed to ensure the registered nurse coordinated with the aide providing services to ensure the patient was receiving appropriate care in 1 of 3 records reviewed of patients receiving home health aide only services with the potential to affect all patients receiving home health aide services. (3)</p> <p>Findings:</p> <p>1. Clinical record 3, start of care 10/31/2011, included plans of care for the certification periods 4/28/12 to 6/26/12 and 6/27/12 to 8/25/12 that evidenced the patient was receiving home health aide services. The record failed to evidence the registered nurse had made a supervisory nurse visit while the home health aide was in the home performing care to ensure the patient was receiving the required care. The record also failed to evidence the registered nurse was aware the patient was receiving wound care from the family member and the family member had instructed the aide not</p>	N0545	<p>·All nursing staff will receive in-service training regarding the POC and care coordination. Specific deficiencies will be reviewed. Instruction will include the regulatory requirement for communication with all disciplines. Communication regarding changes in patient status, orders, & coordination of services will be documented. Documentation reflecting this communication shall include visit notes, minutes of case conference and notations made to the supplemental information form contained in the file. The DON will see every patient admitted/recertified to identify potential problems with coordination of care and changes in patient condition. ·Each clinical record will be reviewed at least every 60 days to ensure reoccurrence does not occur. ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained.</p>	09/20/2012	

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	<p>to wash the patient's feet.</p> <p>2. Home health aide assignment sheet for the home health aide, signed by the registered nurse, Employee B, on 5/15/12 and 7/11/12, evidenced the aide was to clean, file and soak the patient's nails per the patient's request and to soak the feet per the patient's request. The record failed to evidence the registered nurse was aware the aide was not washing and soaking the patient's feet as assigned.</p> <p>3. On 8/21/12 at 11 AM, the Administrator indicated she did not think the aide had to be present for supervisory visits when the patient received home health aide only services. She thought it was an either/or situation.</p>			

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N0567	<p>410 IAC 17-14-1(c)(6) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (6) advise and consult with the family and other home health agency personnel; Based on observation, interview, and document review, the agency failed to ensure the occupational therapist advised the home health aides on the proper usage of a Hoyer in 1 of 1 home health aide visits observed of patients with a Hoyer with the potential to effect all patients with a Hoyer who receiving home health aide (HHA) services. (# 3)</p> <p>Findings:</p> <p>1. On August August 16, 2012, at 11:30 AM, Employee F and H, both HHAs, were at the home of patient # 3 to perform a bed bath and Hoyer transfer. The patient receives home health aide services only. The patient has a diagnosis of Late Effect Cardiovascular Accident. The senior aide, Employee H, prepared two tubs of water with two sets of washcloths and towels. She washed the face, upper torso, and legs of the patients. Without changing the water she washed the abdominal area, scrotal area, and then pulled back the foreskin and washed the penis. Employee F was helping with the rolling of the patient. The patient's feet were not washed as they were bloody and</p>	N0567	<ul style="list-style-type: none"> ·Home Health Aides will complete in-service training for special equipment (Hoyer Lift) from a qualified therapist. ·Home Health Aides will complete in-service training fro safe patient transfer techniques from a qualified therapist. ·The agency will obtain the operation manual for special equipment agency patients are using and incorporate its information in the in-service training material. ·In order to prevent reoccurrence, the DON will see every patient admitted/recertified who is receiving Home Health Aide services, to ensure the HHA assignment sheet is patient specific. She will verify the Home Health Aide assigned to the case has documented skill for that patient's needs. ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012			

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	<p>had bandages on them. After the patient was bathed and dressed, they prepared the patient for transfer to be up for the day. Employee F and H placed the Hoyer sling under the patient, placed the Hoyer legs under the bed (they did not open the Hoyer legs for stability), attached the rings of the sling to the cross arm of the Hoyer, and used the electronic controls to lift the patient. Employee H placed a pillow between the patient's knees and the upright bar of the Hoyer as to not bang the patient's knees and feet. She, walking backwards, guided the Invacare Reliant 450 Hoyer while Employee F stabilized the swinging patient from behind down the approximately 10 foot carpeted hallway and across the approximate 15 foot carpeted living room to the motorized chair. The patient was then successfully lowered into the chair and prepared for the day.</p> <p>2. n 8/20/12 at 10:30 AM, the Administrator indicated they did not have a manual for the Hoyer as the Hoyer was not provided by the agency. The HHAs, Employees F and H, had taken the written test for safety that had 3 questions about the Hoyer. She also indicated there was no documentation the HHAs had performed a competency for any Hoyer though it is customary for the Occupational Therapist to do so.</p>						

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	<p>3. The operation manual for the Invacare Reliant 450 (Hoyer) states, "2.2 Operating Information General</p> <p>WARNING DO NOT use this product or any available optional equipment without first completely reading and understanding these instructions and any additional instructional material such as owner ' s manuals, service manuals or instruction sheets supplied with this product or optional equipment. If you are unable to understand the warnings, cautions or instructions, contact a healthcare professional, dealer or technical personnel before attempting to use this equipment - otherwise, injury or damage may occur.</p> <p>ACCESSORIES WARNING Invacare products are specifically designed and manufactured for use in conjunction with Invacare accessories. Accessories designed by other manufacturers have not been tested by Invacare and are not recommended for use with Invacare products.</p> <p>! NOTICE THE INFORMATION CONTAINED IN THIS DOCUMENT IS SUBJECT TO CHANGE WITHOUT NOTICE.</p>			
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	<p>WARNING</p> <p>The Invacare patient lift is NOT a transport device. It is intended to transfer an individual from one resting surface to another (such as a bed to a wheelchair). Otherwise injury or damage may occur. DO NOT attempt any transfer without approval of the patient ' s physician, nurse or medical assistant. Thoroughly read the instructions in this Owner ' s Manual, observe a trained team of experts perform the lifting procedures and then perform the entire lift procedure several times with proper supervision and a capable individual acting as a patient. Use common sense in all lifts. Special care MUST BE taken with people with disabilities who cannot cooperate while being lifted.</p> <p>© 2011 Invacare Corporation. All rights reserved "</p>			

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N0568	<p>410 IAC 17-14-1(c)(7) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (7) participate in inservice programs.</p> <p>Based on inservices records and interview the agency failed to ensure the Occupational Therapist participated in an inservice for Hoyer use for 2 of 2 home health aides observed caring for a patient with a Hoyer with the potential to effect all patients with a Hoyer that received home health aide services. (F and H)</p> <p>Findings:</p> <ol style="list-style-type: none"> Inservice record F, date of hire (DOH) 6/1/12, failed to evidence the aide had training and a competency evaluation on use of a Hoyer lift. Inservice record H, DOH 1/4/12, failed to evidence the aide had training and a competency evaluation on use of a Hoyer lift. On 8/20/12 at 10:30 AM, the Administrator indicated the HHAs, Employee F and H, had taken the written test for safety that had 3 questions about the Hoyer. She also indicated there was no documentation the HHA's had performed a competency for any Hoyer though it is customary for the 	N0568	<ul style="list-style-type: none"> ·Home Health Aides will complete in-service training for special equipment (Hoyer Lift) from a qualified therapist. ·Home Health Aides will complete in-service training fro safe patient transfer techniques from a qualified therapist. ·The agency will obtain the operation manual for special equipment agency patients are using and incorporate its information in the in-service training material. ·In order to prevent reoccurrence, the DON will see every patient admitted/recertified who is receiving Home Health Aide services, to ensure the HHA assignment sheet is patient specific. She will verify the Home Health Aide assigned to the case has documented skill for that patient's needs. ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012			

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	Occupational Therapist to do so with the training.			

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N0586	<p>410 IAC 17-14-1(h) Scope of Services Rule 14 Sec. 1(h) Home health aides must receive continuing education. Such continuing education shall total at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of eight (8) hours in any eight (8) of the following subject areas:</p> <p>(1) Communications skills, including the ability to read, write, and make brief and accurate oral presentations to patients, caregivers, and other home health agency staff.</p> <p>(2) Observing, reporting, and documenting patient status and the care or service furnished.</p> <p>(3) Reading and recording temperature, pulse, and respiration.</p> <p>(4) Basic infection control procedures and universal precautions.</p> <p>(5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor.</p> <p>(6) Maintaining a clean, safe, and healthy environment.</p> <p>(7) Recognizing emergencies and knowledge of emergency procedures.</p> <p>(8) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, the patient's privacy, and the patient's property.</p> <p>(9) Appropriate and safe techniques in personal hygiene and grooming that include the following:</p> <p>(A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene.</p>						

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	<p>(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.</p> <p>Based on inservice record and policy review and interview, the agency failed to ensure the home health aides completed 12 hours of inservice with 8 hours in the required categories for 6 of 12 home health aide files reviewed of aides employed 12 months in 2011 with the potential to effect all patients receiving home health aide services. (E, I, M, N, U, and V)</p> <p>Findings:</p> <p>1. Inservice record E, date of hire (DOH) 1/28/11, failed to evidence a total at least twelve (12) hours from January 1 through December 31, 2011, inclusive, with a minimum of eight (8) hours in any eight (8) subject areas found in 410 IAC 17-14-1(h).</p> <p>2. Inservice record I, DOH 11/12/03, failed to evidence a total at least twelve (12) hours from January 1 through December 31, 2011, inclusive, with a minimum of eight (8) hours in any eight</p>	N0586	<p>·The DON will immediately begin meeting every Home Health Aide in patient homes to observe the care provided, the performance of the Home Health Aide, and to identify the need for additional in-service training.</p> <p>·This performance review will be conducted annually by the DON, documented, and filed in the employee file.</p> <p>·Home Health Aides shall complete required annual in-service training: 12 hours with a minimum of 8 hours in any eight of the subject areas found in CFR 484.36 (a) and 410 IAC 17-14-1(h), or be subject to termination.</p> <p>·The Administrator will secure arrangements for future competency evaluations to be conducted by a qualified, disinterested, third party.</p> <p>·The competency evaluations will meet regulatory requirements</p> <p>·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained.</p>	09/20/2012

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	<p>(8) subject areas found in 410 IAC 17-14-1(h).</p> <p>3. Inservice record M, DOH 5/1/98, failed to evidence a total at least twelve (12) hours from January 1 through December 31, 2011, inclusive, with a minimum of eight (8) hours in any eight (8) subject areas found in 410 IAC 17-14-1(h).</p> <p>4. Inservice record N, DOH 1/4/99, failed to evidence a total at least twelve (12) hours from January 1 through December 31, 2011, inclusive, with a minimum of eight (8) hours in any eight (8) subject areas found in CFR 484.36 (a) (1).</p> <p>5. Inservice record U, DOH 10/29/08, failed to evidence a total at least twelve (12) hours from January 1 through December 31, 2011, inclusive, with a minimum of eight (8) hours in any eight (8) subject areas found in 410 IAC 17-14-1(h).</p> <p>6. Inservice record V, DOH 1/25/00, failed to evidence a total at least twelve (12) hours from January 1 through December 31, 2011, inclusive, with a minimum of eight (8) hours in any eight (8) subject areas found in 410 IAC 17-14-1(h).</p>			

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	<p>7. On August 21, 2012, at 11 AM, the Administrator, Employee A, indicated the inservices are set but the documentation has not been monitored to make sure the aides are completing inservices required.</p> <p>8. A policy titled "Home Aide Competency Evaluation and Inservice Training", 5/13/09, states, "Current Employees: 1. Annually (January through December) Home Health Aides are required to complete twelve (12) hours of continuing education, with a minimum of eight (8) hours in any eight (8) of the subject areas listed in 410 IAC 17-14-1 Sec. 1 (h) & Federal COP 484.36 (a). The continuing education must be performed by or under the general supervision of a registered nurse."</p>			

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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 Based on personnel record, clinical record, and policy review; observation; and interview, the agency failed to ensure each home health aide (HHA) had completed the competency evaluation requirements in CFR 484.36 (b)(1) before providing home health services for 3 of 20 home health aide files reviewed with the potential to effect all patients who receive home health aide services. (F, H, and S)</p> <p>Findings:</p> <p>1. Personnel record F, date of hire (DOH) 6/1/12, failed to evidence competency evaluation in axillary and ear temperature, respiration, apical pulse, oral: gums, Bed bath: partial, Other bath: tub, Hair: wash-bed and wash-sink, Skin care: massage, Toileting: external catheter, Ambulation: crutches, and Patient Environment: assist with feeding.</p>	N0596	<ul style="list-style-type: none"> ·The DON will immediately begin meeting every Home Health Aide in patient homes to observe the care provided, the performance of the Home Health Aide, and to identify the need for additional in-service training. ·This performance review will be conducted annually by the DON, documented, and filed in the employee file. ·Home Health Aides shall complete required annual in-service training: 12 hours with a minimum of 8 hours in any eight of the subject areas found in CFR 484.36 (a) and 410 IAC 17-14-1(h), or be subject to termination. ·The Administrator will secure arrangements for future competency evaluations to be conducted by a qualified, disinterested, third party. ·The competency evaluations will meet regulatory requirements ·The Administrator is responsible to ensure the deficiency has been corrected & 	09/20/2012			

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	<p>Additional Agency Requirements is blank as completed on 6/4/12 signed by Employee B, Registered Nurse. The form also failed to evidence the aide had been competency tested for a Hoyer lift.</p> <p>A. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Assignment Sheet" created 7/9/12 and signed 7/12/12 for patient 3 indicates the aide assignments are Oral: Gum Care Complete/Assist, Transfer: Hoyer Lift, Hair: Shampoo, Bed.</p> <p>B. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Visit Report" evidences on 6/29/12 the HHA, Employee F, transferred patient #3 by Hoyer.</p> <p>2. Personnel record H, DOH 1/4/12, failed to evidence competency evaluation in Additional Agency Requirement as blank completed 1/6/12 by registered nurse, Employee X. The form failed to evidence the aide had completed a competency for use of the Hoyer lift.</p> <p>A. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Assignment Sheet" created 7/9/12 and signed 7/12/12 for patient 3 indicates the aide assignment is Transfer: Hoyer Lift,</p>		compliance maintained.	

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	<p>B Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Visit Report" evidences on 6/27/12, 6/29/12, and 7/2/12 the HHA, Employee H, transferred the patient by Hoyer.</p> <p>3. A policy titled 'Home Health Aide Competency Evaluation', 5/13/09, states, "Aides will be tested and/or observed in the following areas: ... 10. Safe transfer techniques and ambulation. ... 15 Items 9, 10, and 11 must be demonstrated on a patient or pseudo-patient. ... 16. Documentation of competency testing and evaluation will be maintained in the employee file."</p> <p>4. Personnel file S, DOH 6/26/12, failed to evidence a competency evaluation.</p> <p>A. Clinical record 11, start of care 4/19/2012, included a plan of care for the certification period 7/19/12 to 9/16/12 with orders for HHA 50 units a month prn (as needed) caregiver request, RN to supervise & instruct HHA.</p> <p>B. Clinical record 11 evidenced the HHA S provided care 7/19/12, 7/23/12, 7/26/12 and 7/30/12.</p> <p>5. On 8/20/12 at 10:30 AM, the Administrator indicated the HHAs, Employee F and H, had taken the written</p>				

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	<p>test for safety that had 3 questions about the Hoyer. She also indicated there was no documentation the HHAs had performed a competency for any Hoyer.</p> <p>6. On August August 16, 2012, at 11:30 AM, Employee F and H, both HHAs, were at the home of patient # 3 to perform a bed bath and Hoyer transfer. The patient receives home health aide services only. The patient has a diagnosis of Late Effect Cardiovascular Accident. The senior aide, Employee H, prepared two tubs of water with two sets of washcloths and towels. She washed the face, upper torso, and legs of the patients. Without changing the water she washed the abdominal area, scrotal area, and then pulled back the foreskin and washed the penis. Employee F was helping with the rolling of the patient. The patient's feet were not washed as they were bloody and had bandages on them. After the patient was bathed and dressed, they prepared the patient for transfer to be up for the day. Employee F and H placed the Hoyer sling under the patient, placed the Hoyer legs under the bed (they did not open the Hoyer legs for stability), attached the rings of the sling to the cross arm of the Hoyer, and used the electronic controls to lift the patient. Employee H placed a pillow between the patient's knees and the upright bar of the Hoyer as to not bang</p>			

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	the patient's knees and feet. She, walking backwards, guided the Invacare Reliant 450 Hoyer while Employee F stabilized the swinging patient from behind down the approximately 10 foot carpeted hallway and across the approximate 15 foot carpeted living room to the motorized chair. The patient was then successfully lowered into the chair and prepared for the day.			

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NAME OF PROVIDER OR SUPPLIER DAYBREAK & VISITING NURSE CARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1304 MAIN ST ANDERSON, IN 46016			
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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 personnel record, clinical record, and policy review; observation; and interview, the agency failed to ensure documentation evidenced each home health aide (HHA) had completed the competency evaluation requirements in CFR 484.36 (b)(1) before providing home health services for 3 of 20 home health aide files reviewed with the potential to effect all patients who receive home health aide services. (F, H, and S)</p> <p>Findings:</p> <p>1. Personnel record F, date of hire (DOH) 6/1/12, failed to evidence competency evaluation in axillary and ear temperature, respiration, apical pulse, oral: gums, Bed bath: partial, Other bath: tub, Hair: wash-bed and wash-sink, Skin care: massage, Toileting: external catheter, Ambulation: crutches, and Patient Environment: assist with feeding. Additional Agency Requirements is blank as completed on 6/4/12 signed by Employee B, Registered Nurse. The form also failed to evidence the aide had been</p>	N0598	<ul style="list-style-type: none"> ·The DON will immediately begin meeting every Home Health Aide in patient homes to observe the care provided, the performance of the Home Health Aide, and to identify the need for additional in-service training. ·This performance review will be conducted annually by the DON, documented, and filed in the employee file. ·Home Health Aides shall complete required annual in-service training: 12 hours with a minimum of 8 hours in any eight of the subject areas found in CFR 484.36 (a) and 410 IAC 17-14-1(h), or be subject to termination. ·The Administrator will secure arrangements for future competency evaluations to be conducted by a qualified, disinterested, third party. ·The competency evaluations will meet regulatory requirements ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012			

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	<p>competency tested for a Hoyer lift.</p> <p>A. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Assignment Sheet" created 7/9/12 and signed 7/12/12 for patient 3 indicates the aide assignments are Oral: Gum Care Complete/Assist, Transfer: Hoyer Lift, Hair: Shampoo, Bed.</p> <p>B. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Visit Report" evidences on 6/29/12 the HHA, Employee F, transferred patient #3 by Hoyer.</p> <p>2. Personnel record H, DOH 1/4/12, failed to evidence competency evaluation in Additional Agency Requirement as blank completed 1/6/12 by registered nurse, Employee X. The form failed to evidence the aide had completed a competency for use of the Hoyer lift.</p> <p>A. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Assignment Sheet" created 7/9/12 and signed 7/12/12 for patient 3 indicates the aide assignment is Transfer: Hoyer Lift,</p> <p>B Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Visit Report" evidences on 6/27/12, 6/29/12, and 7/2/12 the HHA, Employee H,</p>				

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	<p>transferred the patient by Hoyer.</p> <p>3. A policy titled "Home Health Aide Competency Evaluation", 5/13/09, states, "Aides will be tested and/or observed in the following areas: ... 10. Safe transfer techniques and ambulation. ... 15 Items 9, 10, and 11 must be demonstrated on a patient or pseudo-patient. ... 16. Documentation of competency testing and evaluation will be maintained in the employee file."</p> <p>4. Personnel file S, DOH 6/26/12, failed to evidence a competency evaluation.</p> <p>A. Clinical record 11, start of care 4/19/2012, included a plan of care for the certification period 7/19/12 to 9/16/12 with orders for HHA 50 units a month prn (as needed) caregiver request, RN to supervise & instruct HHA.</p> <p>B. Clinical record 11 evidenced the HHA S provided care 7/19/12, 7/23/12, 7/26/12 and 7/30/12.</p> <p>5. On 8/20/12 at 10:30 AM, the Administrator indicated the HHAs, Employee F and H, had taken the written test for safety that had 3 questions about the Hoyer. She also indicated there was no documentation the HHAs had performed a competency for any Hoyer.</p>						

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	<p>6. On August August 16, 2012, at 11:30 AM, Employee F and H, both HHAs, were at the home of patient # 3 to perform a bed bath and Hoyer transfer. The patient receives home health aide services only. The patient has a diagnosis of Late Effect Cardiovascular Accident. The senior aide, Employee H, prepared two tubs of water with two sets of washcloths and towels. She washed the face, upper torso, and legs of the patients. Without changing the water she washed the abdominal area, scrotal area, and then pulled back the foreskin and washed the penis. Employee F was helping with the rolling of the patient. The patient's feet were not washed as they were bloody and had bandages on them. After the patient was bathed and dressed, they prepared the patient for transfer to be up for the day. Employee F and H placed the Hoyer sling under the patient, placed the Hoyer legs under the bed (they did not open the Hoyer legs for stability), attached the rings of the sling to the cross arm of the Hoyer, and used the electronic controls to lift the patient. Employee H placed a pillow between the patient's knees and the upright bar of the Hoyer as to not bang the patient's knees and feet. She, walking backwards, guided the Invacare Reliant 450 Hoyer while Employee F stabilized the swinging patient from behind down</p>			
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	the approximately 10 foot carpeted hallway and across the approximate 15 foot carpeted living room to the motorized chair. The patient was then successfully lowered into the chair and prepared for the day.			

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N0603	<p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide may not be assigned to perform additional tasks not included in the original competency evaluation until he or she has successfully been evaluated as competent in that task.</p> <p>Based on personnel record, clinical record and policy review, observation and interview the agency failed to ensure each home health aide (HHA) was qualified to use a Hoyer lift for 2 of 2 home health aides observed using a Hoyer lift with the potential to effect all patients who have a Hoyer lift and receive home health aide services. (F and H)</p> <p>Findings:</p> <p>1. Personnel record F, date of hire (DOH) 6/1/12, failed to evidence competency evaluation in axillary and ear temperature, respiration, apical pulse, oral: gums, Bed bath: partial, Other bath: tub, Hair: wash-bed and wash-sink, Skin care: massage, Toileting: external catheter, Ambulation: crutches, and Patient Environment: assist with feeding. Additional Agency Requirements is blank as completed on 6/4/12 signed by Employee B, Registered Nurse. The form also failed to evidence the aide had been competency tested for a Hoyer lift.</p>	N0603	<ul style="list-style-type: none"> ·The DON will immediately begin meeting every Home Health Aide in patient homes to observe the care provided, the performance of the Home Health Aide, and to identify the need for additional in-service training. ·This performance review will be conducted annually by the DON, documented, and filed in the employee file. ·Home Health Aides shall complete required annual in-service training: 12 hours with a minimum of 8 hours in any eight of the subject areas found in CFR 484.36 (a) and 410 IAC 17-14-1(h), or be subject to termination. ·The Administrator will secure arrangements for future competency evaluations to be conducted by a qualified, disinterested, third party. ·The competency evaluations will meet regulatory requirements ·The Administrator is responsible to ensure the deficiency has been corrected & compliance maintained. 	09/20/2012

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	<p>A. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Assignment Sheet" created 7/9/12 and signed 7/12/12 for patient 3 indicates the aide assignments are Oral: Gum Care Complete/Assist, Transfer: Hoyer Lift, Hair: Shampoo, Bed.</p> <p>B. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Visit Report" evidences on 6/29/12 the HHA, Employee F, transferred patient #3 by Hoyer.</p> <p>2. Personnel record H, DOH 1/4/12, failed to evidence competency evaluation in Additional Agency Requirement as blank completed 1/6/12 by registered nurse, Employee X. The form failed to evidence the aide had completed a competency for use of the Hoyer lift.</p> <p>A. Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Assignment Sheet" created 7/9/12 and signed 7/12/12 for patient 3 indicates the aide assignment is Transfer: Hoyer Lift,</p> <p>B Form titled "Daybreak & Visiting Nurse Care, LLC Home Health Aide Visit Report" evidences on 6/27/12, 6/29/12, and 7/2/12 the HHA, Employee H, transferred the patient by Hoyer.</p>			

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	<p>3. A policy titled "Home Health Aide Competency Evaluation", 5/13/09, states, "Aides will be tested and/or observed in the following areas: ... 10. Safe transfer techniques and ambulation. ... 15 Items 9, 10, and 11 must be demonstrated on a patient or pseudo-patient. ... 16. Documentation of competency testing and evaluation will be maintained in the employee file."</p> <p>4. On 8/20/12 at 10:30 AM, the Administrator indicated the HHAs, Employee F and H, had taken the written test for safety that had 3 questions about the Hoyer. She also indicated there was no documentation the HHAs had performed a competency for any Hoyer.</p> <p>5. On August August 16, 2012, at 11:30 AM, Employee F and H, both HHAs, were at the home of patient # 3 to perform a bed bath and Hoyer transfer. The patient receives home health aide services only. The patient has a diagnosis of Late Effect Cardiovascular Accident. The senior aide, Employee H, prepared two tubs of water with two sets of washcloths and towels. She washed the face, upper torso, and legs of the patients. Without changing the water she washed the abdominal area, scrotal area, and then pulled back the foreskin and washed the penis. Employee F was helping with the</p>			

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	<p>rolling of the patient. The patient's feet were not washed as they were bloody and had bandages on them. After the patient was bathed and dressed, they prepared the patient for transfer to be up for the day. Employee F and H placed the Hoyer sling under the patient, placed the Hoyer legs under the bed (they did not open the Hoyer legs for stability), attached the rings of the sling to the cross arm of the Hoyer, and used the electronic controls to lift the patient. Employee H placed a pillow between the patient's knees and the upright bar of the Hoyer as to not bang the patient's knees and feet. She, walking backwards, guided the Invacare Reliant 450 Hoyer while Employee F stabilized the swinging patient from behind down the approximately 10 foot carpeted hallway and across the approximate 15 foot carpeted living room to the motorized chair. The patient was then successfully lowered into the chair and prepared for the day.</p>			
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