

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/13/2012	
NAME OF PROVIDER OR SUPPLIER FORTE HOME HEALTHCARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 808 A SOUTH HUNTINGTON STREET SYRACUSE, IN 46567			
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G0000	<p>This was an initial Home Health Medicaid certification survey. This was an extended survey.</p> <p>Survey dates: 4/11/12-4/13/12</p> <p>Facility #: 012779</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census: 12</p> <p>Forte Home Healthcare Inc. is precluded from providing it's own home home health aide training and competency evaluation program for a period of two years beginning 4/13/12 through 4/13/14 for being found out of compliance with the Condition of Participation 42 CFR 484.36: Home Health Aide Services.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 20, 2012</p>			G0000	<p>Plan of Correction: Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. See attachment (1). The deficiency has been corrected by contracting with an outside service for training. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p>		

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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G0121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on observation, policy review, and interview, the agency failed to ensure the employees were following infection control practices for 4 of 5 home visit observations with the potential to affect all the agency's patients. (#2, 3, 5, and 6).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During home visit for patient #2 on 4/11/12 at 2:45 PM, employee B was not observed to have washed hands or use hand gel prior to assessing patient and did not clean blood pressure cuff or stethoscope prior to or after use. 2. During home visit for patient #3 on 4/11/12 at 3:30 PM, employee B was not observed to have washed hands or use hand gel prior to assessing patient and did not clean blood pressure cuff or stethoscope prior to or after use. 3. During home visit for patient #5 on 4/13/12 at 11:25 AM, employee B was not observed to have washed hands or use hand gel prior to assessing patient and did not clean blood pressure cuff or 	G0121	<ol style="list-style-type: none"> 1. During home visit for patient #2 on 4/11/12 at 2:45 PM, employee B was not observed to have washed hands or use hand gel prior to assessing patient and did not clean blood pressure cuff or stethoscope prior to or after use. Plan of Correction: Employee B cleaned BP cuff, stethoscope with alcohol wipes in car prior to entering residence. Employee B used hand sanitizer in car prior to entering and leaving homes. This was not observed by the surveyor. A policy has been created for cleaning Medical Equipment and Devices. See Cleaning Medical Equipment and Devices policy in attachment. All staff will be in-services and required to review policy to ensure the deficiency does not recur. The above corrections will be supervised by A. Frazier, RN, BSN. This technique will be reviewed annually in the Continuing Education training curriculum and observed by nursing supervisor during supervisory visits. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 2. During home visit for patient #3 on 4/11/12 at 3:30PM, employee B was not observed to 	05/11/2012			

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	<p>stethoscope prior to or after use.</p> <p>4. During home visit for patient #6 on 4/12/12 at 8:30 AM, Home Health Aide (employee I) was observed providing a tub bath to patient. Employee I did not wash hands prior to donning gloves. After washing the patient's hair and handling the shower sprayer, the Aide provided oral care with a toothbrush but did not change gloves prior to performing the task. The Aide continued the bath with the same pair of gloves and did not change gloves when dressing the patient. The Aide was not observed to have washed the patient's back or perineal area.</p> <p>On 4/12/12 at 1:05 PM, employee B indicated the aide did not wash hands prior to putting on gloves because the aide has eczema, and the aid reported they washed their hands after care was done and patient was in living room with family.</p> <p>5. On 4/11/12 at 3:55 PM, employee B indicated they use hand sanitizer and also clean the equipment used on patients while driving to the next visit.</p> <p>6. On 4/12/12 at 10:20 AM, employee B indicated the agency uses the Lippincott Manual of Nursing Practice for the clinical procedure policies. Employee B</p>		<p>have washed hands or use hand gel prior to assessing patient and did not clean blood pressure cuff or stethoscope prior to or after use. Plan of Correction: Employee B cleaned BP cuff, stethoscope with alcohol wipes in car prior to entering residence. Employee B used hand sanitizer in car prior to entering and leaving homes. This was not observed by the surveyor. A policy has been created for cleaning Medical Equipment and Devices which will be implemented. See Cleaning Medical Equipment and Devices policy in attachment. All staff will be notified and required to review policy to ensure the deficiency does not recur. The above corrections will be supervised by A. Frazier, RN, BSN. This technique will be reviewed annually in the Continuing Education training curriculum and observed by nursing supervisor during supervisory visits. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. During home visit for patient #5 on 4/13/12 at 11:25AM, employee B was not observed to have washed hands or use hand gel prior to assessing patient and did not clean blood pressure cuff or stethoscope prior to or after use. Plan of Correction: Employee B cleaned BP cuff, stethoscope with alcohol wipes in car prior to entering residence. Employee B used hand sanitizer in car prior to</p>				

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	looked up toothbrush procedure and indicated the book did not include the need to use gloves.		entering and leaving homes. This was not observed by the surveyor. A policy has been created for cleaning Medical Equipment and Devices which will be implemented . See Cleaning Medical Equipment and Devices policy in attachment. All staff will be notified and required to review policy to ensure the deficiency does not recur. The above corrections will be supervised by A. Frazier, RN, BSN. This technique will be reviewed annually in the Continuing Education training curriculum and observed by nursing supervisor during supervisory visits. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 4. During home visit for patient #6 on 4/12/12 at 8:30 AM, Home Health Aide (employee I) was observed providing a tub bath to patient. Employee I did not wash hands prior to donning gloves. After washing the patient's hair and handling the shower sprayer, the Aide provided oral care with a toothbrush but did not change gloves prior to performing the task. The Aide continued the bath with the same pair of gloves and did not change gloves when dressing the patient. The Aide was not observed to have washed the patient's back or perineal area. Plan of Correction: Employee I and all employees will be re-instructed and required to review policies of the facility regarding Proper Glove		

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			<p>Use (see Proper Glove Use policy in attachment) practices to ensure the deficiency does not recur. This technique will be reviewed annually in the Continuing Education training curriculum and observed by nursing supervisor during supervisory visits. Employee I was re-instructed on proper bathing techniques on 4/16/12 by A. Doctor RN, MA, MSN, FNP-Bc and will have skills verification by A. Frazier RN, BSN. Employee I has been instructed if for any medical reason she cannot wash her hands prior to putting on gloves a physician's note must be presented. The above corrections will be supervised by A. Frazier, RN, BSN.</p> <p>Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 5. On 4/11/12 at 3:55 PM, employee B indicated they use hand sanitizer and also clean the equipment used on patients while driving to the next visit. Plan of Correction: Employee B cleaned BP cuff, stethoscope with alcohol wipes in car prior to entering residence. Employee B used hand sanitizer in car prior to entering and leaving homes. This was not observed by the surveyor. A policy has been created for cleaning Medical Equipment and Devices which will be implemented May 1, 2012. See Cleaning Medical Equipment and Devices policy in attachment. All staff will be notified and required</p>		

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			to review policy by May 11, 2012 to ensure the deficiency does not recur. The above corrections will be supervised by A. Frazier, RN, BSN. This technique will be reviewed annually in the Continuing Education training curriculum This technique will be reviewed annually in the Continuing Education training curriculum and observed by nursing supervisor during supervisory visits. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 6. On 4/12/12 at 10:20 AM, employee B indicated the agency uses the Lippincott Manual of Nursing Practice for the clinical procedure policies. Employee B looked up toothbrush procedure and indicated the book did not include the need to use gloves. Plan of Correction: Employee I and all employees will be re-instructed and required to review policies of the facility regarding Proper Glove Use (see Proper Glove Use policy in attachment) practices to ensure the deficiency does not recur. This technique will be reviewed annually in the Continuing Education training curriculum and observed by nursing supervisor during supervisory visits. The above corrections will be supervised by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc		

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G0134	<p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.</p> <p>Based on document review, clinical record review, interview, and policy review, the agency failed to ensure Home Health Aides were qualified to provide care by ensuring the completion of a competency evaluation prior to patient care for 7 of 9 home health aide files reviewed with the potential to affect all the patients receiving home health aide services. (employees F, G, I, J, L, N, and O).</p> <p>Findings include:</p> <p>1. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program that addresses each of the subjects listed and be entered on and be in good standing on the state aide registry. 2) Forte HHC shall maintain documentation,</p>	G0134	<p>1. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program that addresses each of the subjects listed and be entered on and be in good standing on the state aide registry. 2) Forte HHC shall maintain documentation, which demonstrate that the requirements of the specified trainings were met." Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not</p>	05/11/2012			

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	<p>which demonstrate that the requirements of the specified trainings were met."</p> <p>2. During interview on 4/13/12 at 1:30 PM, employee B indicated the skills competency observations for the Home Health Aides are done with the supervisory visits and the skills observed are what the Aides have marked as being done on that day. Any skills observations with a home visit are documented on the supervisory visit line. During training the skills are taught and evaluated by verbal return demonstration and observation on a person in the training room and they only watch the aides do a sponge bath.</p> <p>3. Personnel file F, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation.</p> <p>A. On 4/13/12 at 10:50 AM, employee B indicated that employee F was checked off for skills, but did not complete the test or training for Home Health Aide since employee F was a Certified Nursing Assistant and they complete 150 hours of training versus a Home Health Aide who only completes 75 hours.</p> <p>B. On 4/13/12 at 1:15 PM, employee B indicated they let employee F test out of the book work for Home Health Aide</p>		<p>receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel</p>				

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	<p>since the employee was already a Certified Nursing Assistant but the employee completed the 16 hours of instruction and skills check offs all in one day. Employee B also indicated they had asked questions of employee F using Nurse Aide Training Program Curriculum material in lieu of a written test.</p> <p>3. Personnel file G, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation.</p> <p>A. The Skill Instruction and Observation sheets dated 1/19/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>B. Clinical record #12 evidenced Employee G, first patient contact date 3/2/12, was assigned to patient #12 and provided a shower and "shaved legs and armpits" on 3/2, 3/16, 3/23, 3/30, and 4/6/12. On 3/9/12, a shower was provided. Skills / Observation sheet in file failed to evidence shaving of legs and underarm was competency tested.</p> <p>4. Personnel file I, date of hire 2/22/12, indicates the 16 hours of classroom</p>		<p>file. All elements of the standard will be monitored during supervisory visits. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 2. During interview on 4/13/12 at 1:30 PM, employee B indicated the skills competency observations for the Home Health Aides are done with the supervisory visits and the skills observed are what the Aides have marked as being done on that day. Any skills observations with a home visit are documented on the supervisory visit line. During training the skills are taught and evaluated by verbal return demonstration and observation on a person in the training room and they only watch the aides do a sponge bath. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific</p>				

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	<p>training and Skills Assessment Training / Observation were completed on 2/20/12.</p> <p>A. The Skill Instruction and Observation sheets dated 2/20/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>B. Clinical record #6 evidenced Employee I, first patient contact date 2/22/12, provided a tub bath on 2/22, 2/29, and 3/5/12. Skills observation was not documented until 3/7/12.</p> <p>5. Personnel file J, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>6. Personnel file L, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets</p>		<p>requirement during skills observation. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. Personnel file F, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation. A. On 4/13/12 at 10:50 AM, employee B indicated</p>				

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	<p>dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>7. Personnel file M, date of hire 2/14/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 2/14/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>8. Personnel file N, date of hire 3/20/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 3/5/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>9. Personnel file O, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation</p>		<p>that employee F was checked off for skills, but did not complete the test or training for Home Health Aide since employee F was a Certified Nursing Assistant and they complete 150 hours of training versus a Home Health Aide who only completes 75 hours. B. On 4/13/12 at 1:15 PM, employee B indicated they let employee F test out of the book work for Home Health Aide since the employee was already a Certified Nursing Assistant but the employee completed the 16 hours of instruction and skills check offs all in one day. Employee B also indicated they had asked questions of employee F using Nurse Aide Training Program Curriculum material in lieu of a written test. Plan of Correction: Employee F is no longer providing Home Health Aide services as of 4/16/12, due to not having Home Health Aide status in the state registry, and was informed by A. Doctor RN,MS,MSN,FNP. Employee F was informed that when she has completed the state requirements for home health aide training and submitted the proper documentation and skills validation she may return as an employee. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. Personnel file G, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation. A. The Skill</p>				

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	<p>for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>Clinical record #4 evidenced Employee O, first patient contact date 2/22/12, was assigned to provide care to the patient and provided a shower on 2/25, 2/29, 3/14, 3/21, and 4/4/12.</p> <p>10. During home visit with patient #6 on 4/12/12 at 8:30 AM, employee B indicated when they do supervisory visits with observation of skills to watch to the Aides do personal care with clients, they (employee B) give the patients their privacy and just listen outside the room as the Aide describes what they are doing.</p> <p>11. On 4/13/12 at 1:45 PM 1:45 PM, employee B indicated that employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were already on the Home Health Aide Registry so the agency figured that was all they needed to prove competency testing.</p>		<p>Instruction and Observation sheets dated 1/19/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee B misunderstood the question by surveyor concerning aidesreceiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. All home health aides will be observed and competency evaluated for bathing (tub, shower, and bed) and shampoo (sink, tub, or bed) by A. Frazier, RN, BSN Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. Clinical record #12 evidenced Employee G, first patient contact date 3/2/12, was assigned to patient #12 and</p>				

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			provided a shower and "shaved legs and armpits" on 3/2, 3/16, 3/23, 3/30, and 4/6/12. On 3/9/12, a shower was provided. Skills / Observation sheet in file failed to evidence shaving of legs and underarm was competency tested. Plan of Correction: Employee G instructed to not do any shaving of patient and to follow nursing plan of care on 4/26/12. All home health aides will be instructed to follow nursing plan of care and not perform any skills they have not been competency evaluated for by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 4. Personnel file I, date of hire 2/22/12, indicates the 16 hours of classroom training and Skills Assessment Training / Observation were completed on 2/20/12. Plan of Correction: The form presented to the surveyor demonstrated that instruction was verified during home health aide training. See attached 16 hours skills assessment training completion form. Assessment completed by Belinda Blosser, RN. A. The Skill Instruction and Observation sheets dated 2/20/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee B misunderstood the question by				

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			<p>surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent</p>				

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			<p>personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. Clinical record #6 evidenced Employee I, first patient contact date 2/22/12, provided a tub bath on 2/22, 2/29, and 3/5/12. Skills observation was not documented until 3/7/12. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See</p>	

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			<p>attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. On 2/22/12 employee I was observed to complete bath by B. Blosser, RN. See attachment. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 5. Personnel file J, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee J was terminated on 3/15/12. All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be</p>		

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			administered by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 6. Personnel file L, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency				

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			validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 7. Personnel file M, date of hire 2/14/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 2/14/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees who were trained by the agency, had already received their 16 hours of training during				

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			<p>their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 8. Personnel file N, date of hire 3/20/12, failed to evidence a completed home</p>		

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			<p>health aide competency evaluation. The Skill Instruction and Observation sheets dated 3/5/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training</p>		

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			<p>deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 9. Personnel file O, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Clinical record #4 evidenced Employee O, first patient contact date 2/22/12, was assigned to provide care to the patient and provided a shower on 2/25, 2/29, 3/14, 3/21, and 4/4/12. Plan of Correction: Employee B misunderstood the question by</p>		

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			<p>surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a</p>		

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			<p>written test. The training and testing will be administered by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 10. During home visit with patient #6 on 4/12/12 at 8:30 AM, employee B indicated when they do supervisory visits with observation of skills to watch to the Aides do personal care with clients, they (employee B) give the patients their privacy and just listen outside the room as the Aide describes what they are doing. Plan of Correction: This statement is incorrect. Employee B was referencing standing outside the patient's room and listening/observing while the patient was getting ready for bath and shower was observed. This is in respect for patient's privacy. While it is the policy of Forte HHC to treat each patient with respect and dignity by limiting the number of people in the room while the patient is being undressed and prepared for bathing, supervisory visits will now be conducted within direct sight of patient and employee effective 4/16/12. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 11. On 4/13/12 at 1:45 PM 1:45 PM, employee B indicated that employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were already on the Home Health Aide Registry so the agency figured</p>		

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			that was all they needed to prove competency testing. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy		

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			Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training/competency validation to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc		

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G0159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review, policy review, observation, and interview, the agency failed to ensure the durable medical equipment was listed on the Plan of Care and the certification periods were for a 60 day period for 12 of 12 records reviewed with the potential to affect all the agency's 12 patients. (#1-12)</p> <p>Findings include:</p> <p>1. Clinical record #1 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12.</p> <p>A. Start of Care date is listed as 2/20/12. The physician order to "Assess client for home health care" is dated 2/21/12. The Comprehensive Assessment, Consent to Receive Services, Release of Information, and Service</p>	G0159	<p>1. Clinical record #1 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A. Start of Care date is listed as 2/20/12. The physician order to "Assess client for home health care" is dated 2/21/12. The Comprehensive Assessment, Consent to Receive Services, Release of Information, and Service Relationship Agreement forms are dated 2/21/12. Plan of Correction: Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. Recertification dates have been corrected on forms according to policy by A. Doctor RN, MA, MSN, FNP-Bc. The orders signed by physician were for 60 days, so were correct orders. All dates will be verified by the supervising nurse and office personnel responsible for faxing and filing. Errors were corrected</p>	05/11/2012			

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NAME OF PROVIDER OR SUPPLIER FORTE HOME HEALTHCARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 808 A SOUTH HUNTINGTON STREET SYRACUSE, IN 46567			
(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			
	<p>Relationship Agreement forms are dated 2/21/12.</p> <p>B. The Home Safety Checklist, General Health Assessment, and Progress Notes are dated 2/20/12.</p> <p>C. The record evidenced a physician order to "encourage movement & activities" dated 2/21/12. This order was not listed on the plan of care.</p> <p>2. Clinical record #2 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12.</p> <p>A. A second certification period was started on 3/5/12 when Skilled Nursing services was added, the certification period listed is 3/5/12 - 5/4/12. The certification period beginning 3/5/12 should have ended on 5/3/12.</p> <p>B. Physician orders to "Assess client for home health care" is dated 2/21/12. The client Medication List is dated 2/18/12, and Progress Notes are dated 2/20/12.</p> <p>C. On 4/11/12 at 2:45 PM during home visit, a wheel chair was seen in the home. Wheelchair is not listed under</p>		<p>on 4/27/12 according to policy. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. The Home Safety Checklist, General Health Assessment, and Progress Notes are dated 2/20/12. Plan of Correction: The dates have been corrected by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager, on 4/14/12. All dates will be verified by the supervising nurse and office personnel responsible for faxing and filing. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc C. The record evidenced a physician order to "encourage movement & activities" dated 2/21/12. This order was not listed on the plan of care. Plan of Correction: This patient has been discharged as of 3/15/12. A Nursing Plan of Care has been created by A. Doctor RN, MS, MSN, FNP-BC, and added to each client file and in-home binder, effective 4/27/12. This form will be mandatory for each client. See attachment for Nursing Plan of Care form. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p> <p>2. Clinical record #2 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. Plan of Correction: Agency has downloaded the</p>				

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	<p> durable medical equipment and supplies on the plan of care. The client's family member and employee B indicated the wheelchair belonged to the client.</p> <p>3. Clinical record #3 contained a plan of care for the certification period 3/8/12 - 4/7/12. The certification period beginning 3/8/12 should have ended on 5/6/12. On 4/11/12 at 3:30 PM, during home visit, the patient was observed to be sitting in a wheelchair. The wheelchair is not specified on the plan of care.</p> <p>4. Clinical record #4 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/15/12 when Skilled Nursing services was added. The certification period listed is 3/15/12 - 5/14/12. The certification period beginning 3/15/12 should have ended on 5/13/12.</p> <p>5. Clinical record #5 contained a plan of care for the certification period 3/27/12 - 5/26/12. The certification period beginning 3/27/12 should have ended on 5/25/12.</p> <p>6. Clinical record #6 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period</p>		<p>"OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager on 4/14/12. Recertification dates have been corrected on forms according to policy by A. Doctor RN, MA, MSN, FNP-Bc. The orders signed by physician were for 60 days, so were correct orders. All dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc A. A second certification period was started on 3/5/12 when Skilled Nursing services was added, the certification period listed is 3/5/12 - 5/4/12. The certification period beginning 3/5/12 should have ended on 5/3/12. Plan of Correction: The dates were corrected on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager by 4/14/12. All dates will be verified by the supervising nurse and office personnel responsible for faxing and filing. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. Physician orders to "Assess client for home health care" is dated 2/21/12. The client Medication List is dated 2/18/12, and Progress Notes are dated 2/20/12. Plan of Correction: The</p>				

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	<p>beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/5/12 when Skilled Nursing services was added. The certification period listed is 3/5/12 - 5/4/12. The certification period beginning 3/5/12 should have ended on 5/3/12. On 4/12/12 at 8:30 AM during home visit, the client was observed to be in a wheelchair. The wheelchair is not listed on the plan of care.</p> <p>7. Clinical record #7 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/20/12 when Skilled Nursing services was added, the certification period listed is 3/20/12 - 5/19/12. The certification period beginning 3/20/12 should have ended on 5/18/12.</p> <p>8. Clinical record #8 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/13/12 when Skilled Nursing services was added, the certification period listed is 3/13/12 - 5/12/12. The certification period beginning 3/13/12 should have ended on</p>		<p>dates were corrected on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. All dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc C. On 4/11/12 at 2:45 PM during home visit, a wheel chair was seen in the home. Wheelchair is not listed under durable medical equipment and supplies on the plan of care. The client's family member and employee B indicated the wheelchair belonged to the client. Plan of Correction: Wheelchair was added to the plan of care on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Future assessments will include all durable medical equipment. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. Clinical record #3 contained a plan of care for the certification period 3/8/12 - 4/7/12. The certification period beginning 3/8/12 should have ended on 5/6/12. On 4/11/12 at 3:30 PM, during home visit, the patient was observed to be sitting in a wheelchair. The wheelchair is not specified on the plan of care. Plan of Correction: The dates were corrected on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc.</p>				

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	<p>5/11/12.</p> <p>9. Clinical record #9 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/5/12 when Skilled Nursing services was added, the certification period listed is 3/5/12 - 5/4/12. The certification period beginning 3/5/12 should have ended on 5/3/12.</p> <p>10. Clinical record #10 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12.</p> <p>11. Clinical record #11 contained a plan of care for the certification period 3/27/12 -5/26/12. The certification period beginning 3/27/12 should have ended on 5/25/12.</p> <p>12. Clinical record #12 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12.</p> <p>13. The agency's policy titled "Medical Plan of Care" #5.1, not dated, states "The</p>		<p>Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. All dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Wheelchair has been added to the plan of care by A. Doctor RN, MA, MSN, FNP-Bc. Future assessments will include all durable medical equipment. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 4. Clinical record #4 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/15/12 when Skilled Nursing services was added. The certification period listed is 3/15/12 - 5/14/12. The certification period beginning 3/15/12 should have ended on 5/13/12. Plan of Correction: The dates were corrected on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. All dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 5. Clinical record #5 contained a plan of care for the</p>				

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	<p>plan of care shall include: ... 2) The services to be furnished and equipment required."</p> <p>14. During interview on 4/11/12 at 12:55 PM, employee B indicated the dates for clinical records #1 and #2 were mis-dated and services were provided on 2/20, not 2/21. The physician orders should also be dated 2/20. Also the medication list for clinical record #2 was received on the date indicated as the agency received the list early, before care was provided.</p>		<p>certification period 3/27/12 - 5/26/12. The certification period beginning 3/27/12 should have ended on 5/25/12. Plan of Correction: The dates were corrected on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. All dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 6. Clinical record #6 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/5/12 when Skilled Nursing services was added. The certification period listed is 3/5/12 - 5/4/12. The certification period beginning 3/5/12 should have ended on 5/3/12. On 4/12/12 at 8:30 AM during home visit, the client was observed to be in a wheelchair. The wheelchair is not listed on the plan of care. Plan of Correction: The dates were corrected on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. All dates will be verified</p>				

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			<p>by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Wheelchair has been added to the plan of care by A. Doctor RN, MA, MSN, FNP-Bc. Future assessments will include all durable medical equipment. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 7. Clinical record #7 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/20/12 when Skilled Nursing services was added, the certification period listed is 3/20/12 - 5/19/12. The certification period beginning 3/20/12 should have ended on 5/18/12. Plan of Correction: The dates were corrected on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. All dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 8. Clinical record #8 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on</p>		

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			3/13/12 when Skilled Nursing services was added, the certification period listed is 3/13/12 - 5/12/12. The certification period beginning 3/13/12 should have ended on 5/11/12. Plan of Correction: The dates were corrected on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. All dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 9. Clinical record #9 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/5/12 when Skilled Nursing services was added, the certification period listed is 3/5/12 - 5/4/12. The certification period beginning 3/5/12 should have ended on 5/3/12. Plan of Correction: The dates were corrected on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. All dates will be verified by the supervising nurse and office personnel responsible for		

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			<p>faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 10. Clinical record #10 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. Plan of Correction: The dates were corrected on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. All dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 11. Clinical record #11 contained a plan of care for the certification period 3/27/12 -5/26/12. The certification period beginning 3/27/12 should have ended on 5/25/12. Plan of Correction: The dates were corrected on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. All dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 12. Clinical record #12 contained a</p>		

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			<p>plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. Plan of Correction: The dates were corrected on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. All dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 13. The agency's policy titled "Medical Plan of Care" #5.1, not dated, states "The plan of care shall include: ... 2) The services to be furnished and equipment required." Plan of Correction: Future assessments will include a survey of all durable medical equipment to be assured that it is listed on the plan of care. This information will be validated during supervisory visits. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 14. During interview on 4/11/12 at 12:55 PM, employee B indicated the dates for clinical records #1 and #2 were mis-dated and services were provided on 2/20, not 2/21. The physician orders should also be dated 2/20. Also the medication list for clinical record #2 was received on the date indicated as the agency</p>		

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			received the list early, before care was provided. Plan of Correction: The dates were corrected on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. All dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc	

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G0166	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS</p> <p>Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure physician's verbal and telephone orders were signed by the physician within the time frame stated in the agency's policy for 1 of 12 records reviewed with the potential to affect all the agency's patients. (#6)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #6 contained a physician order dated 3/1/12 that stated, "Family requests that HHA [Home Health Aide] visit be 1x/week x 2 hours x 60 days [one time per week for two hours for 60 days], or 1x every 2 weeks x 60 days, MD office notified and approved change." As of 4/13/12, this order had not been signed by the doctor. 2. The agency's policy titled "Client Orders / Notification of Change in Client Status" #5.3, not dated, states "The registered nurse may accept written orders for home health services from a 	G0166	<ol style="list-style-type: none"> 1. Clinical record #6 contained a physician order dated 3/1/12 that stated, "Family requests that HHA [Home Health Aide] visit be 1x/week x 2 hours x 60 days [one time per week for two hours for 60 days], or 1x every 2 weeks x 60 days, MD office notified and approved change." As of 4/13/12, this order had not been signed by the doctor. Plan of Correction: Order resent to MD for signature by C. Gaham, Office Manager, and was signed by Dr Szuba on 4/27/12. See attachment. Supervisor will be informed on day 6 if any order has not been received. Order will be re-faxed and physician office will be called, effective 4/26/12 Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 2. The agency's policy titled "Client Orders / Notification of Change in Client Status" #5.3, not dated, states "The registered nurse may accept written orders for home health services from a physician, licensed in Indiana or in any other state. If Forte HHC (Home Health Care) receives a verbal order from a physician, it must be signed within one (1) week of receipt." Plan of 	05/11/2012			

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	<p>physician, licensed in Indiana or in any other state. If Forte HHC (Home Health Care) receives a verbal order from a physician, it must be signed within one (1) week of receipt."</p> <p>3. During interview on 4/11/12 at 10:00 AM, employee B indicated they would have to look at the policy in regards to the time frame for physicians to sign orders. Employee B also indicated this order was written incorrectly and should be 1 hour 2 times per week or 2 hours one time per week.</p>		<p>Correction: Unsigned orders have been resent to MDs for signature by C. Gaham, Office Manager, and were signed on 4/26/12. Future signatures will be checked by Office Manager and office personnel responsible for filing and faxing. Supervisor will be informed on day 6 if any order has not been received. Order will be re-faxed and physician office will be called, effective 4/26/12 Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. During interview on 4/11/12 at 10:00 AM, employee B indicated they would have to look at the policy in regards to the time frame for physicians to sign orders. Employee B also indicated this order was written incorrectly and should be 1 hour 2 times per week or 2 hours one time per week. Plan of Correction: Order was corrected according to policy and resent to MD for signature by C. Gaham, Office Manager, and was signed on 4/26/12. Future signatures will be checked by Office Manager and office personnel responsible for filing and faxing. Supervisor will be informed on day 6 if any order has not been received. Order will be re-faxed and physician office will be called, effective 4/26/12 Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p>		

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G0202	<p>484.36 HOME HEALTH AIDE SERVICES</p> <p>Based on document review, clinical record review, observation, interview, and policy review, it was determined the agency failed to ensure Home Health Aides completed a competency evaluation prior to patient care for 7 of 9 home health aide files reviewed with the potential to affect all the patients receiving home health aide services (See G 211 and G 212), failed to ensure Home Health Aides completed a competency evaluation prior to patient care that included observations of the aide's performance of the specified skills for 7 of 9 home health aide files reviewed with the potential to affect all the patients receiving home health aide services (See G 218), failed to ensure documentation evidenced Home Health Aides completed a competency evaluation prior to patient care for 7 of 9 home health aide files reviewed with the potential to affect all the patients receiving home health aide services (See G 221), failed to ensure the home health aides received written plans of care for the clients for 9 of 12 records reviewed of patients receiving home health aide services with the potential to affect all of the agency's patients receiving home health aide services (See G 224), and failed to ensure the registered</p>			G0202	<p>Based on document review, clinical record review, observation, interview, and policy review, it was determined the agency failed to ensure Home Health Aides completed a competency evaluation prior to patient care for 7 of 9 home health aide files reviewed with the potential to affect all the patients receiving home health aide services (See G 211 and G 212), Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files.</p> <p>Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation.</p>		05/11/2012

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	<p>nurse completed a supervisory visit every 14 days in 1 of 8 records reviewed of patients who received skilled and home health aide services for longer than 14 days (See G 229).</p> <p>The cumulative effect of these systemic problems resulted in the agency being unable to meet the requirements of the Condition of Participation 484.36: Home Health Aide Services.</p>		<p>Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction.</p> <p>Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc failed to ensure Home Health Aides completed a competency evaluation prior to patient care that included observations of the aide's performance of the specified skills for 7 of 9 home health aide</p>				

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			files reviewed with the potential to affect all the patients receiving home health aide services (See G 218), Plan of Correction: Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc failed to ensure documentation evidenced Home Health Aides completed a competency evaluation prior to patient care for 7 of 9 home health aide files reviewed with the potential to affect all the patients receiving home health aide services (See G 221), Plan of Correction: Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is		

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			<p>required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc failed to ensure the home health aides received written plans of care for the clients for 9 of 12 records reviewed of patients receiving home health aide services with the potential to affect all of the agency's patients receiving home health aide services (See G 224), Plan of Correction: Although no regulation states that the physician plan of care cannot also be utilized as a multidisciplinary plan of care, including home health services, Forte HHC has implemented a Nursing Plan of Care for all patient records. This Plan of Care form was completed for all patients by A. Doctor, RN, MA, MSN, FNP-Bc on 4/27/12 and can be found in the attachment document as form Nursing Plan of Care. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc and failed to ensure the registered nurse completed a supervisory visit every 14 days in 1 of 8 records reviewed of patients who received skilled and home health aide services for longer than 14 days (See G 229). Plan of Correction: Forte HHC has implemented an online</p>		

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			calendar to track supervisory visits. This calendar will be updated with the receipt of all patient documentation. A. Doctor RN, MA, MSN, FNP-Bc will be notified by day 13 of needed supervisory visits to ensure that they are completed every 14 days. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc		

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G0211	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI An individual may furnish home health aide services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this paragraph.</p> <p>Based on document review, clinical record review, interview, and policy review, the agency failed to ensure Home Health Aides completed a competency evaluation prior to patient care for 7 of 9 home health aide files reviewed with the potential to affect all the patients receiving home health aide services. (employees F, G, I, J, L, N, and O).</p> <p>Findings include:</p> <p>1. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program that addresses each of the subjects listed and be entered on and be in good standing on the state aide registry. 2) Forte HHC shall maintain documentation,</p>	G0211	<p>1. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program that addresses each of the subjects listed and be entered on and be in good standing on the state aide registry. 2) Forte HHC shall maintain documentation, which demonstrate that the requirements of the specified trainings were met." Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry</p>	05/11/2012			

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	<p>which demonstrate that the requirements of the specified trainings were met."</p> <p>2. During interview on 4/13/12 at 1:30 PM, employee B indicated the skills competency observations for the Home Health Aides are done with the supervisory visits and the skills observed are what the Aides have marked as being done on that day. Any skills observations with a home visit are documented on the supervisory visit line. During training the skills are taught and evaluated by verbal return demonstration and observation on a person in the training room and they only watch the aides do a sponge bath.</p> <p>3. Personnel file F, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation.</p> <p>A. On 4/13/12 at 10:50 AM, employee B indicated that employee F was checked off for skills, but did not complete the test or training for Home Health Aide since employee F was a Certified Nursing Assistant and they complete 150 hours of training versus a Home Health Aide who only completes 75 hours.</p> <p>B. On 4/13/12 at 1:15 PM, employee B indicated they let employee F test out of the book work for Home Health Aide</p>		<p>were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training by 5/11/12. See attachment. The deficiency has been corrected by contracting with an outside service for training. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p> <p>2. During interview on 4/13/12 at 1:30 PM, employee B indicated the skills competency observations for the Home Health Aides are done with the</p>				

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	<p>since the employee was already a Certified Nursing Assistant but the employee completed the 16 hours of instruction and skills check offs all in one day. Employee B also indicated they had asked questions of employee F using Nurse Aide Training Program Curriculum material in lieu of a written test.</p> <p>3. Personnel file G, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation.</p> <p>A. The Skill Instruction and Observation sheets dated 1/19/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>B. Clinical record #12 evidenced Employee G, first patient contact date 3/2/12, was assigned to patient #12 and provided a shower and "shaved legs and armpits" on 3/2, 3/16, 3/23, 3/30, and 4/6/12. On 3/9/12, a shower was provided. Skills / Observation sheet in file failed to evidence shaving of legs and underarm was competency tested.</p> <p>4. Personnel file I, date of hire 2/22/12, indicates the 16 hours of classroom</p>		<p>supervisory visits and the skills observed are what the Aides have marked as being done on that day. Any skills observations with a home visit are documented on the supervisory visit line. During training the skills are taught and evaluated by verbal return demonstration and observation on a person in the training room and they only watch the aides do a sponge bath. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each</p>				

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	<p>training and Skills Assessment Training / Observation were completed on 2/20/12.</p> <p>A. The Skill Instruction and Observation sheets dated 2/20/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>B. Clinical record #6 evidenced Employee I, first patient contact date 2/22/12, provided a tub bath on 2/22, 2/29, and 3/5/12. Skills observation was not documented until 3/7/12.</p> <p>5. Personnel file J, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>6. Personnel file L, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets</p>		<p>employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. Personnel file F, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation. Plan of Correction: Employee F is no longer providing home health aide services as of 4/16/12, and was informed by A. Doctor RN, MA, MSN, FNP-Bc, due to registry status of CNA and not HHA. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc A. On 4/13/12 at 10:50 AM, employee B indicated that</p>				

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	<p>dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>7. Personnel file M, date of hire 2/14/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 2/14/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>8. Personnel file N, date of hire 3/20/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 3/5/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>9. Personnel file O, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation</p>		<p>employee F was checked off for skills, but did not complete the test or training for Home Health Aide since employee F was a Certified Nursing Assistant and they complete 150 hours of training versus a Home Health Aide who only completes 75 hours. Plan of Correction: Employee F is no longer providing home health aide services as of 4/16/12, and was informed by A. Doctor RN, MA, MSN, FNP-Bc, due to registry status of CNA and not HHA. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. On 4/13/12 at 1:15 PM, employee B indicated they let employee F test out of the book work for Home Health Aide since the employee was already a Certified Nursing Assistant but the employee completed the 16 hours of instruction and skills check offs all in one day. Employee B also indicated they had asked questions of employee F using Nurse Aide Training Program Curriculum material in lieu of a written test. Plan of Correction: Employee F is no longer providing home health aide services as of 4/16/12, and was informed by A. Doctor RN, MA, MSN, FNP-Bc, due to registry status of CNA and not HHA. In the future, Forte HHC will not accept CNA status as qualification for Home Health Aide services. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. Personnel file G,</p>				

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NAME OF PROVIDER OR SUPPLIER FORTE HOME HEALTHCARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 808 A SOUTH HUNTINGTON STREET SYRACUSE, IN 46567			
(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			
	<p>for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>Clinical record #4 evidenced Employee O, first patient contact date 2/22/12, was assigned to provide care to the patient and provided a shower on 2/25, 2/29, 3/14, 3/21, and 4/4/12.</p> <p>10. During home visit with patient #6 on 4/12/12 at 8:30 AM, employee B indicated when they do supervisory visits with observation of skills to watch to the Aides do personal care with clients, they (employee B) give the patients their privacy and just listen outside the room as the Aide describes what they are doing.</p> <p>11. On 4/13/12 at 1:45 PM 1:45 PM, employee B indicated that employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were already on the Home Health Aide Registry so the agency figured that was all they needed to prove competency testing.</p>		<p>date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation. Plan of Correction: Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. All home health aides will be competency checked by A. Frazier, RN, BSN for tub, shower, and bed bath. All home health aides will be observed and competency evaluated for bathing (tub, shower, and bed) by A. Frazier, RN, BSN Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc A. The Skill Instruction and Observation sheets dated 1/19/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these</p>				

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			skills were instructed and/or observed. Plan of Correction: Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. All home health aides will be competency checked by A. Frazier, RN, BSN for tub, shower, and bed bath. All home health aides will be observed and competency evaluated for bathing (tub, shower, and bed) by A. Frazier, RN, BSN Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. Clinical record #12 evidenced Employee G, first patient contact date 3/2/12, was assigned to patient #12 and provided a shower and "shaved legs and armpits" on 3/2, 3/16, 3/23, 3/30, and 4/6/12. On 3/9/12, a shower was provided. Skills / Observation sheet in file failed to evidence shaving of legs		

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			and underarm was competency tested. Plan of Correction: Employee G instructed not to shave legs and armpits of patient and follow nursing plan of care by A. Doctor, RN, MA, MSN, FNP-Bc. All home health aides will be instructed to follow the nursing plan of care and not perform any skills they have not been competency evaluated for by Amy Frazier RN, BSN. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 4. Personnel file I, date of hire 2/22/12, indicates the 16 hours of classroom training and Skills Assessment Training / Observation were completed on 2/20/12. Plan of Correction: Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. All home health aides will be competency checked by A. Frazier, RN, BSN for tub, shower, and bed bath. All home health aides will be		

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			<p>observed and competency evaluated for bathing (tub, shower, and bed) by A. Frazier, RN, BSN Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p> <p>A. The Skill Instruction and Observation sheets dated 2/20/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p> <p>B. Clinical record #6 evidenced Employee I, first patient contact date 2/22/12, provided a tub bath on 2/22, 2/29, and 3/5/12. Skills observation was not documented until 3/7/12. Plan of Correction: Employees verified as being on the home health aide registry were not required and did</p>		

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			not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. All home health aides will be competency checked by A. Frazier, RN, BSN for tub, shower, and bed bath. All home health aides will be observed and competency evaluated for bathing (tub, shower, and bed) by A. Frazier, RN, BSN Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 5. Personnel file J, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee J was terminated on 3/15/12 by A. Doctor RN, MA, MSN, FNP-Bc. All home health aides will be competency checked by A. Frazier, RN, BSN for tub, shower, and bed bath and sink, tub, or bed shampoo. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 6. Personnel file L, date of hire 1/23/12, failed to evidence		

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			<p>a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. All home health aides will be competency checked by A. Frazier, RN, BSN for tub, shower, and bed bath. All home health aides will be observed and competency evaluated for bathing (tub, shower, and bed) and bed, sink, or tub shampoo by A. Frazier, RN, BSN Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 7. Personnel file M, date of hire 2/14/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 2/14/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or</p>	

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			<p>bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction:</p> <p>Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction.</p> <p>All home health aides will be competency checked by A. Frazier, RN, BSN for tub, shower, and bed bath. All home health aides will be observed and competency evaluated for bathing (tub, shower, and bed) and bed, sink, or tub shampoo by A. Frazier, RN, BSN Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 8. Personnel file N, date of hire 3/20/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 3/5/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to</p>		

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			<p>indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction:</p> <p>Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction.</p> <p>All home health aides will be competency checked by A. Frazier, RN, BSN for tub, shower, and bed bath. All home health aides will be observed and competency evaluated for bathing (tub, shower, and bed) and shampoo, sink, tub, or bed, by A. Frazier, RN, BSN Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 9. Personnel file O, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation</p>	

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			<p>of which of these skills were instructed and/or observed. Plan of Correction: Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation.</p> <p>All home health aides will be competency checked by A. Frazier, RN, BSN for tub, shower, and bed bath. All home health aides will be observed and competency evaluated for bathing (tub, shower, and bed) and shampooing (sink, tub, or bed) by A. Frazier, RN, BSN Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc Clinical record #4 evidenced Employee O, first patient contact date 2/22/12, was assigned to provide care to the patient and provided a shower on 2/25, 2/29, 3/14, 3/21, and 4/4/12. Plan of Correction: Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. Thehome health aide skills validation form has signatures under "instruction"because employee B asked each employee if they had received instruction in each</p>		

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			<p>specific requirement during skills observation.</p> <p>All home health aides will be competency checked by A. Frazier, RN, BSN for tub, shower, and bed bath. All home health aides will be observed and competency evaluated for bathing (tub, shower, and bed) by A. Frazier, RN, BSN Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 10. During home visit with patient #6 on 4/12/12 at 8:30 AM, employee B indicated when they do supervisory visits with observation of skills to watch to the Aides do personal care with clients, they (employee B) give the patients their privacy and just listen outside the room as the Aide describes what they are doing. Plan of Correction: This statement is incorrect. Employee B was referencing standing outside the patient's room and listening/observing while the patient was getting ready for bath, and shower was observed. This is in respect for patient's privacy. While it is the policy of Forte HHC to treat each patient with respect and dignity by limiting the number of people in the room while the patient is being undressed and prepared for bathing, supervisory visits will now be conducted within direct sight of patient and employee effective 4/16/12.</p> <p>Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 11. On 4/13/12 at 1:45 PM 1:45 PM, employee B indicated that</p>		

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			<p>employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were already on the Home Health Aide Registry so the agency figured that was all they needed to prove competency testing. Plan of Correction:</p> <p>Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation.</p> <p>Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. All aides will be competency checked by A. Frazier, RN, BSN.</p> <p>The deficiency has been corrected by contracting with an outside service for training. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p>		

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G0212	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>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 document review, clinical record review, interview, and policy review, the agency failed to ensure Home Health Aides completed a competency evaluation prior to patient care for 7 of 9 home health aide files reviewed with the potential to affect all the patients receiving home health aide services. (employees F, G, I, J, L, N, and O).</p> <p>Findings include:</p> <p>1. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program that addresses each of the subjects listed and be entered on and be in good standing on the state aide registry. 2) Forte HHC shall maintain documentation, which demonstrate that the requirements of the specified trainings were met."</p>	G0212	<p>1. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program that addresses each of the subjects listed and be entered on and be in good standing on the state aide registry. 2) Forte HHC shall maintain documentation, which demonstrate that the requirements of the specified trainings were met." Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not</p>	05/11/2012			

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	<p>2. During interview on 4/13/12 at 1:30 PM, employee B indicated the skills competency observations for the Home Health Aides are done with the supervisory visits and the skills observed are what the Aides have marked as being done on that day. Any skills observations with a home visit are documented on the supervisory visit line. During training the skills are taught and evaluated by verbal return demonstration and observation on a person in the training room and they only watch the aides do a sponge bath.</p> <p>3. Personnel file F, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation.</p> <p>A. On 4/13/12 at 10:50 AM, employee B indicated that employee F was checked off for skills, but did not complete the test or training for Home Health Aide since employee F was a Certified Nursing Assistant and they complete 150 hours of training versus a Home Health Aide who only completes 75 hours.</p> <p>B. On 4/13/12 at 1:15 PM, employee B indicated they let employee F test out of the book work for Home Health Aide since the employee was already a Certified Nursing Assistant but the</p>		<p>receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. See attachment (1). The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible</p>				

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	<p>employee completed the 16 hours of instruction and skills check offs all in one day. Employee B also indicated they had asked questions of employee F using Nurse Aide Training Program Curriculum material in lieu of a written test.</p> <p>3. Personnel file G, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation.</p> <p>A. The Skill Instruction and Observation sheets dated 1/19/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>B. Clinical record #12 evidenced Employee G, first patient contact date 3/2/12, was assigned to patient #12 and provided a shower and "shaved legs and armpits" on 3/2, 3/16, 3/23, 3/30, and 4/6/12. On 3/9/12, a shower was provided. Skills / Observation sheet in file failed to evidence shaving of legs and underarm was competency tested.</p> <p>4. Personnel file I, date of hire 2/22/12, indicates the 16 hours of classroom training and Skills Assessment Training / Observation were completed on 2/20/12.</p>		<p>Person: A. Doctor RN, MA, MSN, FNP-Bc 2. During interview on 4/13/12 at 1:30 PM, employee B indicated the skills competency observations for the Home Health Aides are done with the supervisory visits and the skills observed are what the Aides have marked as being done on that day. Any skills observations with a home visit are documented on the supervisory visit line. During training the skills are taught and evaluated by verbal return demonstration and observation on a person in the training room and they only watch the aides do a sponge bath. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Employees who were trained by the agency, had</p>				

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	<p>A. The Skill Instruction and Observation sheets dated 2/20/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>B. Clinical record #6 evidenced Employee I, first patient contact date 2/22/12, provided a tub bath on 2/22, 2/29, and 3/5/12. Skills observation was not documented until 3/7/12.</p> <p>5. Personnel file J, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>6. Personnel file L, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and</p>		<p>already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. See attachment (1). The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. Personnel file F, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation. Plan of Correction: Employee F was informed by A. Doctor, RN, MA, MSN, FNP-BC, that she could no longer provide care until she received home health aid</p>				

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	<p>also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>7. Personnel file M, date of hire 2/14/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 2/14/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>8. Personnel file N, date of hire 3/20/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 3/5/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>9. Personnel file O, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There</p>		<p>training. In the future all employees will be verified on the state registry. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc A. On 4/13/12 at 10:50 AM, employee B indicated that employee F was checked off for skills, but did not complete the test or training for Home Health Aide since employee F was a Certified Nursing Assistant and they complete 150 hours of training versus a Home Health Aide who only completes 75 hours. Plan of Correction: Employee F was informed effective 4/16/12, by A. Doctor, RN, MA, MSN, FNP-BC, that she could no longer provide care until she received home health aid training. In the future all employees will be verified on the state registry. Forte HHC will no longer accept CNA certifications for Home Health Aide positions. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. On 4/13/12 at 1:15 PM, employee B indicated they let employee F test out of the book work for Home Health Aide since the employee was already a Certified Nursing Assistant but the employee completed the 16 hours of instruction and skills check offs all in one day. Employee B also indicated they had asked questions of employee F using Nurse Aide Training Program Curriculum material in lieu of a written test. Plan of Correction: Employee F was informed by A.</p>				

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	<p>are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>Clinical record #4 evidenced Employee O, first patient contact date 2/22/12, was assigned to provide care to the patient and provided a shower on 2/25, 2/29, 3/14, 3/21, and 4/4/12.</p> <p>10. During home visit with patient #6 on 4/12/12 at 8:30 AM, employee B indicated when they do supervisory visits with observation of skills to watch to the Aides do personal care with clients, they (employee B) give the patients their privacy and just listen outside the room as the Aide describes what they are doing.</p> <p>11. On 4/13/12 at 1:45 PM 1:45 PM, employee B indicated that employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were already on the Home Health Aide Registry so the agency figured that was all they needed to prove competency testing.</p>		<p>Doctor, RN, MA, MSN, FNP-BC, that she could no longer provide care until she received home health aid training. In the future all employees will be verified on the state registry. Forte HHC will no longer accept CNA certifications for Home Health Aide positions. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. Personnel file G, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation. Plan of Correction: Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. See attachment (1). The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent</p>				

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			<p>personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc A. The Skill Instruction and Observation sheets dated 1/19/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. Clinical record #12 evidenced Employee G, first patient contact date 3/2/12, was assigned to patient #12 and provided a shower and "shaved legs and armpits" on 3/2, 3/16, 3/23, 3/30, and 4/6/12. On 3/9/12, a shower was provided. Skills / Observation sheet in file failed to evidence shaving of legs and underarm was competency tested. Plan of Correction: Employee G was informed by A. Doctor RN, MA, MSN, FNP-Bc, that she could no longer perform these duties. Employees will be in-serviced that they must follow nursing plan of care by A Frazier RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 4. Personnel file I, date of hire 2/22/12, indicates the 16 hours of classroom training and</p>		

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			Skills Assessment Training / Observation were completed on 2/20/12. A. The Skill Instruction and Observation sheets dated 2/20/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. Clinical record #6 evidenced Employee I, first patient contact date 2/22/12, provided a tub bath on 2/22, 2/29, and 3/5/12. Skills observation was not documented until 3/7/12. Plan of Correction: Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under				

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			<p>"instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 5. Personnel file J, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee J was terminated 3/15/12 by A. Doctor, RN, MA, MSN, FNP-Bc. The deficiency has been corrected by contracting with an outside service for training. The outside</p>				

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			<p>service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met and competencies have been verified. That documentation will be stored in the employee's permanent personnel file. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 6. Personnel file L, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. The deficiency has been corrected by contracting</p>		

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			with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met and competencies have been verified. That documentation will be stored in the employee's permanent personnel file. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 7. Personnel file M, date of hire 2/14/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 2/14/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training.		

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			The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met and competencies have been verified. That documentation will be stored in the employee's permanent personnel file. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 8. Personnel file N, date of hire 3/20/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 3/5/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed Plan of Correction: Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health		

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			<p>aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met and competencies have been verified. That documentation will be stored in the employee's permanent personnel file. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 9. Personnel file O, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were</p>		

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			<p>instructed and/or observed. Plan of Correction: Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met and competencies have been verified. That documentation will be stored in the employee's permanent personnel file. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc Clinical record #4 evidenced Employee O, first patient contact date 2/22/12, was assigned to provide care to the patient and provided a shower on 2/25, 2/29, 3/14, 3/21, and 4/4/12. Plan of Correction: The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply</p>		

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NAME OF PROVIDER OR SUPPLIER FORTE HOME HEALTHCARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 808 A SOUTH HUNTINGTON STREET SYRACUSE, IN 46567			
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			documentation for each Home Health Aide that goes through training to prove the requirements have been met and competencies have been verified. That documentation will be stored in the employee's permanent personnel file. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 10. During home visit with patient #6 on 4/12/12 at 8:30 AM, employee B indicated when they do supervisory visits with observation of skills to watch to the Aides do personal care with clients, they (employee B) give the patients their privacy and just listen outside the room as the Aide describes what they are doing. Plan of Correction: This statement is incorrect. Employee B was referencing standing outside the patient's room and listening/observing while the patient was getting ready for bath, and shower was observed. This is in respect for patient's privacy. While it is the policy of Forte HHC to treat each patient with respect and dignity by limiting the number of people in the room while the				

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			<p>patient is being undressed and prepared for bathing, supervisory visits will now be conducted within direct sight of patient and employee effective 4/16/12.</p> <p>Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 11. On 4/13/12 at 1:45 PM 1:45 PM, employee B indicated that employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were already on the Home Health Aide Registry so the agency figured that was all they needed to prove competency testing. Plan of Correction:</p> <p>Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation.</p> <p>The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met and competencies have been verified. That documentation will be stored in the employee's permanent</p>		

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			personnel file. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc		

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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 document review, clinical record review, interview, and policy review, the agency failed to ensure Home Health Aides completed a competency evaluation prior to patient care that included observations of the aide's performance of the specified skills for 7 of 9 home health aide files reviewed with the potential to affect all the patients receiving home health aide services. (employees F, G, I, J, L, N, and O).</p> <p>Findings include:</p> <p>1. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully</p>	G0218	<p>1. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program that addresses each of the subjects listed and be entered on and be in good standing on the state aide registry. 2) Forte HHC shall maintain documentation, which demonstrate that the requirements of the specified trainings were met." Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as</p>	05/11/2012			

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	<p>completed a competency evaluation program that addresses each of the subjects listed and be entered on and be in good standing on the state aide registry. 2) Forte HHC shall maintain documentation, which demonstrate that the requirements of the specified trainings were met."</p> <p>2. During interview on 4/13/12 at 1:30 PM, employee B indicated the skills competency observations for the Home Health Aides are done with the supervisory visits and the skills observed are what the Aides have marked as being done on that day. Any skills observations with a home visit are documented on the supervisory visit line. During training the skills are taught and evaluated by verbal return demonstration and observation on a person in the training room and they only watch the aides do a sponge bath.</p> <p>3. Personnel file F, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation.</p> <p>A. On 4/13/12 at 10:50 AM, employee B indicated that employee F was checked off for skills, but did not complete the test or training for Home Health Aide since employee F was a Certified Nursing Assistant and they complete 150 hours of training versus a Home Health Aide who only completes</p>		<p>evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home HealthAide that goes through training to prove the requirements have been met and competencies have been verified. That documentation will be stored in the employee's permanent personnel file. Employees will not be allowed to perform tasks</p>				

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	<p>75 hours.</p> <p>B. On 4/13/12 at 1:15 PM, employee B indicated they let employee F test out of the book work for Home Health Aide since the employee was already a Certified Nursing Assistant but the employee completed the 16 hours of instruction and skills check offs all in one day. Employee B also indicated they had asked questions of employee F using Nurse Aide Training Program Curriculum material in lieu of a written test.</p> <p>3. Personnel file G, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation.</p> <p>A. The Skill Instruction and Observation sheets dated 1/19/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>B. Clinical record #12 evidenced Employee G, first patient contact date 3/2/12, was assigned to patient #12 and provided a shower and "shaved legs and armpits" on 3/2, 3/16, 3/23, 3/30, and 4/6/12. On 3/9/12, a shower was provided. Skills / Observation sheet in</p>		<p>without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 2. During interview on 4/13/12 at 1:30 PM, employee B indicated the skills competency observations for the Home Health Aides are done with the supervisory visits and the skills observed are what the Aides have marked as being done on that day. Any skills observations with a home visit are documented on the supervisory visit line. During training the skills are taught and evaluated by verbal return demonstration and observation on a person in the training room and they only watch the aides do a sponge bath. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B</p>				

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	<p>file failed to evidence shaving of legs and underarm was competency tested.</p> <p>4. Personnel file I, date of hire 2/22/12, indicates the 16 hours of classroom training and Skills Assessment Training / Observation were completed on 2/20/12.</p> <p>A. The Skill Instruction and Observation sheets dated 2/20/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>B. Clinical record #6 evidenced Employee I, first patient contact date 2/22/12, provided a tub bath on 2/22, 2/29, and 3/5/12. Skills observation was not documented until 3/7/12.</p> <p>5. Personnel file J, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p>		<p>asked each employee if they had received instruction in each specific requirement during skills observation. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future home health aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A.</p>				

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	<p>6. Personnel file L, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>7. Personnel file M, date of hire 2/14/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 2/14/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>8. Personnel file N, date of hire 3/20/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 3/5/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p>		<p>Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. Personnel file F, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation. A. On 4/13/12 at 10:50 AM, employee B indicated that employee F was checked off for skills, but did not complete the test or training for Home Health Aide since employee F was a Certified Nursing Assistant and they complete 150 hours of training versus a Home Health Aide who only completes 75 hours. B. On 4/13/12 at 1:15 PM, employee B indicated they let employee F test out of the book work for Home Health Aide since the employee was already a Certified Nursing Assistant but the employee completed the 16 hours of instruction and skills check offs all in one day. Employee B also indicated they had asked questions of employee F using Nurse Aide Training Program Curriculum material in lieu of a written test. Plan of Correction: Employee F is no longer providing Home Health Aide services as of 4/16/12, due to not having Home Health Aide status in the state registry, and was informed by A. Doctor RN,MS,MSN,FNP. Employee F was informed that when she has completed the state requirements for home health aide training and submitted the proper documentation and skills</p>				

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	<p>9. Personnel file O, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>Clinical record #4 evidenced Employee O, first patient contact date 2/22/12, was assigned to provide care to the patient and provided a shower on 2/25, 2/29, 3/14, 3/21, and 4/4/12.</p> <p>10. During home visit with patient #6 on 4/12/12 at 8:30 AM, employee B indicated when they do supervisory visits with observation of skills to watch to the Aides do personal care with clients, they (employee B) give the patients their privacy and just listen outside the room as the Aide describes what they are doing.</p> <p>11. On 4/13/12 at 1:45 PM 1:45 PM, employee B indicated that employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were already on the Home Health Aide Registry so the agency figured that was all they needed to prove</p>		<p>validation she may return as an employee. Forte Home Health Care will no longer accept CNA certification for home health aide positions. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p> <p>3. Personnel file G, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation. A. The Skill Instruction and Observation sheets dated 1/19/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction:</p> <p>Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation.</p> <p>All home health aides will be observed and competency evaluated for bathing (tub, shower, and bed) and bed, sink, and tub shampooing by A. Frazier, RN, BSN Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in</p>				

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	competency testing.		<p>home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. Clinical record #12 evidenced Employee G, first patient contact date 3/2/12, was assigned to patient #12 and provided a shower and "shaved legs and armpits" on 3/2, 3/16, 3/23, 3/30, and 4/6/12. On 3/9/12, a shower was provided. Skills / Observation sheet in file failed to evidence shaving of legs and underarm was competency tested. Plan of Correction: Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation.</p> <p>All home health aides will be observed and competency evaluated for bathing (tub, shower, and bed) by A. Frazier, RN, BSN</p> <p>All home health aides will be instructed to follow the nursing plan of care and not perform any skills they have not been competency evaluated for by Amy Frazier RN, BSN.</p> <p>Employee G instructed to not shave legs and armpits of patient on 4/27/12 by A. Doctor, RN, MA, MSN, FNP. Responsible Person:</p>		

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			A. Doctor RN, MA, MSN, FNP-Bc 4. Personnel file I, date of hire 2/22/12, indicates the 16 hours of classroom training and Skills Assessment Training / Observation were completed on 2/20/12. Plan of Correction: The form presented to the surveyor demonstrated that instruction was verified during skills checkoff by Belinda Blosser, RN. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. A. The Skill Instruction and Observation sheets dated 2/20/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. Clinical record #6 evidenced Employee I, first		

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			<p>patient contact date 2/22/12, provided a tub bath on 2/22, 2/29, and 3/5/12. Skills observation was not documented until 3/7/12. Plan of Correction: Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 5. Personnel file J, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Personnel file J has been terminated by A. Doctor, RN, MA, MSN, FNP-Bc effective 3/15/12. All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the</p>		

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NAME OF PROVIDER OR SUPPLIER FORTE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 808 A SOUTH HUNTINGTON STREET SYRACUSE, IN 46567		
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			<p>requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 6. Personnel file L, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 7. Personnel file M, date of hire 2/14/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction</p>		

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			and Observation sheets dated 2/14/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 8. Personnel file N, date of hire 3/20/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 3/5/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction:All home health		

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			<p>aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 9. Personnel file O, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Clinical record #4 evidenced Employee O, first patient contact date 2/22/12, was assigned to provide care to the patient and provided a shower on 2/25, 2/29, 3/14, 3/21, and 4/4/12. Plan of Correction: All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test.</p>	

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			<p>The training and testing will be administered by A. Frazier, RN, BSN. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 10. During home visit with patient #6 on 4/12/12 at 8:30 AM, employee B indicated when they do supervisory visits with observation of skills to watch to the Aides do personal care with clients, they (employee B) give the patients their privacy and just listen outside the room as the Aide describes what they are doing. Plan of Correction: This statement is incorrect. Employee B was referencing standing outside the patient's room and listening/observing while the patient was getting ready for bath and shower was observed. This is in respect for patient's privacy. While it is the policy of Forte HHC to treat each patient with respect and dignity by limiting the number of people in the room while the patient is being undressed and prepared for bathing, supervisory visits will now be conducted within direct sight of patient and employee effective 4/16/12. Responsible Person: A. Doctor</p>		

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			<p>RN, MA, MSN, FNP-Bc 11. On 4/13/12 at 1:45 PM 1:45 PM, employee B indicated that employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were already on the Home Health Aide Registry so the agency figured that was all they needed to prove competency testing. Plan of Correction: Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training/competency validation to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</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 document review, clinical record review, interview, and policy review, the agency failed to ensure documentation evidenced Home Health Aides completed a competency evaluation prior to patient care for 7 of 9 home health aide files reviewed with the potential to affect all the patients receiving home health aide services. (employees F, G, I, J, L, N, and O).</p> <p>Findings include:</p> <p>1. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program that addresses each of the subjects listed and be entered on and be in good standing on the state aide registry. 2) Forte HHC shall maintain documentation, which demonstrate that the requirements of the specified trainings were met."</p>	G0221	<p>1. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program that addresses each of the subjects listed and be entered on and be in good standing on the state aide registry. 2) Forte HHC shall maintain documentation, which demonstrate that the requirements of the specified trainings were met." Plan of Correction: Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That</p>	05/11/2012			

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	<p>2. During interview on 4/13/12 at 1:30 PM, employee B indicated the skills competency observations for the Home Health Aides are done with the supervisory visits and the skills observed are what the Aides have marked as being done on that day. Any skills observations with a home visit are documented on the supervisory visit line. During training the skills are taught and evaluated by verbal return demonstration and observation on a person in the training room and they only watch the aides do a sponge bath.</p> <p>3. Personnel file F, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation.</p> <p>A. On 4/13/12 at 10:50 AM, employee B indicated that employee F was checked off for skills, but did not complete the test or training for Home Health Aide since employee F was a Certified Nursing Assistant and they complete 150 hours of training versus a Home Health Aide who only completes 75 hours.</p> <p>B. On 4/13/12 at 1:15 PM, employee B indicated they let employee F test out of the book work for Home Health Aide since the employee was already a Certified Nursing Assistant but the</p>		<p>documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 2. During interview on 4/13/12 at 1:30 PM, employee B indicated the skills competency observations for the Home Health Aides are done with the supervisory visits and the skills observed are what the Aides have marked as being done on that day. Any skills observations with a home visit are documented on the supervisory visit line. During training the skills are taught and evaluated by verbal return demonstration and observation on a person in the training room and they only watch the aides do a sponge bath. Plan of Correction: Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. Personnel file F, date of hire 1/19/12, failed to evidence</p>				

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	<p>employee completed the 16 hours of instruction and skills check offs all in one day. Employee B also indicated they had asked questions of employee F using Nurse Aide Training Program Curriculum material in lieu of a written test.</p> <p>3. Personnel file G, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation.</p> <p>A. The Skill Instruction and Observation sheets dated 1/19/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>B. Clinical record #12 evidenced Employee G, first patient contact date 3/2/12, was assigned to patient #12 and provided a shower and "shaved legs and armpits" on 3/2, 3/16, 3/23, 3/30, and 4/6/12. On 3/9/12, a shower was provided. Skills / Observation sheet in file failed to evidence shaving of legs and underarm was competency tested.</p> <p>4. Personnel file I, date of hire 2/22/12, indicates the 16 hours of classroom training and Skills Assessment Training / Observation were completed on 2/20/12.</p>		<p>a home health aide completed competency evaluation. Plan of Correction: Employee F is no longer providing Home Health Aide services as of 4/16/12, due to not having Home Health Aide status in the state registry, and was informed by A. Doctor RN,MS,MSN,FNP. Employee F was informed that when she has completed the state requirements for home health aide training and submitted the proper documentation and skills validation she may return as an employee. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc A. On 4/13/12 at 10:50 AM, employee B indicated that employee F was checked off for skills, but did not complete the test or training for Home Health Aide since employee F was a Certified Nursing Assistant and they complete 150 hours of training versus a Home Health Aide who only completes 75 hours. Plan of Correction: The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home HealthAide that goes through training to prove the requirements have been met and competencies have been verified. That documentation will be stored in the employee's permanent personnel file. Employees will not be allowed to perform tasks without being observed and</p>				

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	<p>A. The Skill Instruction and Observation sheets dated 2/20/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>B. Clinical record #6 evidenced Employee I, first patient contact date 2/22/12, provided a tub bath on 2/22, 2/29, and 3/5/12. Skills observation was not documented until 3/7/12.</p> <p>5. Personnel file J, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>6. Personnel file L, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and</p>		<p>competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. On 4/13/12 at 1:15 PM, employee B indicated they let employee F test out of the book work for Home Health Aide since the employee was already a Certified Nursing Assistant but the employee completed the 16 hours of instruction and skills check offs all in one day. Employee B also indicated they had asked questions of employee F using Nurse Aide Training Program Curriculum material in lieu of a written test. Plan of Correction: Forte Home Health Care will no longer accept certifications of CNA for Home Health Aide positions. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home HealthAide that goes through training to prove the requirements have been met and competencies have been verified. That documentation will be stored in the employee's permanent personnel file. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN,</p>				

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	<p>also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>7. Personnel file M, date of hire 2/14/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 2/14/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>8. Personnel file N, date of hire 3/20/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 3/5/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>9. Personnel file O, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There</p>		<p>FNP-Bc 3. Personnel file G, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation. Plan of Correction: The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home HealthAide that goes through training to prove the requirements have been met and competencies have been verified. That documentation will be stored in the employee's permanent personnel file. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc A. The Skill Instruction and Observation sheets dated 1/19/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: All home health aides will be observed and competency evaluated for bathing (tub, shower, and bed) and also shampoo, sink, tub, or bed by A. Frazier, RN, BSN The deficiency has been corrected by contracting with an outside service for training. The outside service is</p>				

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	<p>are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>Clinical record #4 evidenced Employee O, first patient contact date 2/22/12, was assigned to provide care to the patient and provided a shower on 2/25, 2/29, 3/14, 3/21, and 4/4/12.</p> <p>10. During home visit with patient #6 on 4/12/12 at 8:30 AM, employee B indicated when they do supervisory visits with observation of skills to watch to the Aides do personal care with clients, they (employee B) give the patients their privacy and just listen outside the room as the Aide describes what they are doing.</p> <p>11. On 4/13/12 at 1:45 PM 1:45 PM, employee B indicated that employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were already on the Home Health Aide Registry so the agency figured that was all they needed to prove competency testing.</p>		<p>required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. Clinical record #12 evidenced Employee G, first patient contact date 3/2/12, was assigned to patient #12 and provided a shower and "shaved legs and armpits" on 3/2, 3/16, 3/23, 3/30, and 4/6/12. On 3/9/12, a shower was provided. Skills / Observation sheet in file failed to evidence shaving of legs and underarm was competency tested. Plan of Correction: All home health aides will be observed and competency evaluated for bathing (tub, shower, and bed) by A. Frazier, RN, BSN Employee G instructed to not shave legs and armpits of patient on 4/27/12 by A. Doctor, RN, MA, MSN, FNP.</p> <p>All home health aides will be instructed to follow the nursing plan of care and not perform any skills they have not been competency evaluated for by Amy Frazier RN, BSN.</p> <p>Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 4. Personnel file I, date of hire 2/22/12, indicates the 16 hours of classroom training and Skills Assessment Training / Observation were completed on 2/20/12. Plan of Correction: The</p>				

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			form presented to the surveyor demonstrated that instruction was verified during instruction. See attached 16 hours skills assessment training completion form. Assessment completed by Belinda Blosser, RN. A. The Skill Instruction and Observation sheets dated 2/20/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. Clinical record #6 evidenced Employee I, first patient contact date 2/22/12, provided a tub bath on 2/22, 2/29, and 3/5/12. Skills observation was not documented until 3/7/12. Plan of Correction: On 2/22/12 employee I was observed to complete bath by B. Blosser, RN. See attachment. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN,				

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			<p>FNP-Bc 5. Personnel file J, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee J has been terminated by A. Doctor RN, MA, MSN, FNP-Bc, effective 3/15/12. All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p> <p>6. Personnel file L, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo,</p>				

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			<p>sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home HealthAide that goes through training to prove the requirements have been met and competencies have been verified. That documentation will be stored in the employee's permanent personnel file. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 7. Personnel file M, date of hire 2/14/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 2/14/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be</p>		

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			administered by A. Frazier, RN, BSN. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home HealthAide that goes through training to prove the requirements have been met and competencies have been verified. That documentation will be stored in the employee's permanent personnel file. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 8. Personnel file N, date of hire 3/20/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 3/5/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction:All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. The deficiency has been corrected by contracting				

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			with an outside service for training. The outside service is required to supply documentation for each Home HealthAide that goes through training to prove the requirements have been met and competencies have been verified. That documentation will be stored in the employee's permanent personnel file. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 9. Personnel file O, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Clinical record #4 evidenced Employee O, first patient contact date 2/22/12, was assigned to provide care to the patient and provided a shower on 2/25, 2/29, 3/14, 3/21, and 4/4/12. Plan of Correction: All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be		

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			administered by A. Frazier, RN, BSN. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home HealthAide that goes through training to prove the requirements have been met and competencies have been verified. That documentation will be stored in the employee's permanent personnel file. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 10. During home visit with patient #6 on 4/12/12 at 8:30 AM, employee B indicated when they do supervisory visits with observation of skills to watch to the Aides do personal care with clients, they (employee B) give the patients their privacy and just listen outside the room as the Aide describes what they are doing. Plan of Correction: This statement is incorrect. Employee B was referencing standing outside the patient's room and listening/observing while the patient was getting ready for bath and shower was observed. This is in respect for patient's privacy. While it is the policy of Forte HHC to treat each patient with respect and dignity by limiting the number of people in				

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			<p>the room while the patient is being undressed and prepared for bathing, supervisory visits will now be conducted within direct sight of patient and employee effective 4/16/12. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 11. On 4/13/12 at 1:45 PM, employee B indicated that employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were already on the Home Health Aide Registry so the agency figured that was all they needed to prove competency testing. Plan of Correction: Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training/competency validation to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p>		

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G0224	<p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on clinical record review, observation during home visits, policy review, and interview, the agency failed to ensure the home health aides received written plans of care for the clients for 9 of 12 records reviewed of patients receiving home health aide services with the potential to affect all of the agency's patients receiving home health aide services. (#1, 2, 4, 6, 7, 8, 9, 10, and 12).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical records #1, 2, 4, 6, 7, 8, 9, 10, and 12 failed to evidence a Home Health Aide Care Plan. During home visit to patient #6 on 4/12/12 at 8:30 AM, the record in the home failed to evidence a home health aide care plan. 2. On 4/11/11 at 1:05 PM, employee B indicated the Plan of Care is used as the aide care plan. 3. The agency's policy titled "Assignment and Duties of the Home Health Aide," 	G0224	<ol style="list-style-type: none"> 1. Clinical records #1, 2, 4, 6, 7, 8, 9, 10, and 12 failed to evidence a Home Health Aide Care Plan. During home visit to patient #6 on 4/12/12 at 8:30 AM, the record in the home failed to evidence a home health aide care plan. Plan of Correction: Although no regulation states that the physician plan of care cannot also be utilized as a multidisciplinary plan of care, including home health services, Forte HHC has implemented a Nursing Plan of Care for all patient records. This Plan of Care form was completed by A. Doctor, RN, MA, MSN, FNP-Bc on 4/27/12 and can be found in the attachment document as form Nursing Plan of Care. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 2. On 4/11/11 at 1:05 PM, employee B indicated the Plan of Care is used as the aide care plan. Plan of Correction: Although no regulation states that the physician plan of care cannot also be utilized as a multidisciplinary plan of care, including home health services, Forte HHC has implemented a Nursing Plan of Care for all patient records. This 	05/11/2012			

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	#7.8, not dated, states, "The home health aide is assigned to a specific client by the registered nurse. Written client care instructions for the home health aide must be prepared by the registered nurse / nursing supervisor who is responsible for the supervision of the home health aide."		Plan of Care form was completed by A. Doctor, RN, MA, MSN, FNP-Bc on 4/27/12 and can be found in the attachment document as form Nursing Plan of Care. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. The agency's policy titled "Assignment and Duties of the Home Health Aide," #7.8, not dated, states, "The home health aide is assigned to a specific client by the registered nurse. Written client care instructions for the home health aide must be prepared by the registered nurse / nursing supervisor who is responsible for the supervision of the home health aide." Plan of Correction: Although no regulation states that the physician plan of care cannot also be utilized as a multidisciplinary plan of care, including home health services, Forte HHC has implemented a Nursing Plan of Care for all patient records. This Plan of Care form was completed by A. Doctor, RN, MA, MSN, FNP-Bc on 4/27/12 and can be found in the attachment document as form Nursing Plan of Care. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc				

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G0229	<p>484.36(d)(2) SUPERVISION</p> <p>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record review, the agency failed to ensure the registered nurse completed a supervisory visit every 14 days in 1 of 8 records reviewed of patients who received skilled and home health aide services for longer than 14 days. (#6)</p> <p>Findings include:</p> <p>Clinical record #6, start of care 2/20/12, evidenced the patient received skilled and home health aide services. The record failed to evidence a Home Health Aide supervisory visit had been completed between 3/28/12 and 4/12/12.</p>	G0229	<p>Clinical record #6, start of care 2/20/12, evidenced the patient received skilled and home health aide services. The record failed to evidence a Home Health Aide supervisory visit had been completed between 3/28/12 and 4/12/12. Plan of Correction: Forte HHC has implemented an online calendar to track supervisory visits. This calendar will be updated with the receipt of all patient documentation. A. Doctor RN, MA, MSN, FNP-Bc will be notified by day 13 of needed supervisory visits to ensure that they are completed every 14 days. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p>	05/11/2012			

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N0416	<p>410 IAC-17-10-1(k) LICENSURE Rule 10 Sec. 1(k) In conducting a survey, a surveyor shall receive copies of any and all documents necessary to make a determination of compliance. The surveyor may do either of the following: (1) Make copies with the permission of the home health agency. (2) Supervise any copying process to ensure that photocopies are true and accurate. At the sole discretion of the department and for good cause shown, the home health agency may be granted up to twenty-four (24) hours to produce documents requested by the surveyor.</p> <p>Based on clinical record review and interview, the agency failed to provide Home Health Aide sheets from patient record #10 and all policies as requested by surveyor for 1 of 1 agency.</p> <p>Findings include:</p> <p>1. Home Health Aide notes from clinical record #10 were not provided. These were requested on 4/13/12 at 2 PM.</p> <p>2. On 4/12/12 at 10:00 AM, surveyor requested policy and procedures for handwashing and infection control. These were not provided by end of survey on 4/13/12.</p>	N0416	<p>1. Home Health Aide notes from clinical record #10 were not provided. These were requested on 4/13/12 at 2 PM. Plan of correction: Surveyor was asked after each record was copied by C. Gaham if anything else needed to be copied. The surveyor did not request copies of record #10's progress notes. This was also not mentioned during the exit interview. Copies of patient #10's aide notes have been provided by A. Doctor RN, MA, MSN, FNP-Bc. See Attachment. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p> <p>2. On 4/12/12 at 10:00 AM, surveyor requested policy and procedures for handwashing and infection control. These were not provided by end of survey on 4/13/12. Plan of correction: Surveyor requested to view, but did not ask for copy of policies. Copies of Infection Control</p>	05/11/2012			

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			Policies (handwashing policy, exposure control plan and proper glove use) have been attached to survey. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc	

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N0446	<p>410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3)</p> <p>Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations.</p> <p>Based on document review, clinical record review, interview, and policy review, the agency failed to ensure Home Health Aides were qualified to provide care by ensuring the completion of a competency evaluation prior to patient care for 7 of 9 home health aide files reviewed with the potential to affect all the patients receiving home health aide services. (employees F, G, I, J, L, N, and O).</p> <p>Findings include:</p> <p>1. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program that addresses each of the</p>	N0446	<p>1. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program that addresses each of the subjects listed and be entered on and be in good standing on the state aide registry. 2) Forte HHC shall maintain documentation, which demonstrate that the requirements of the specified trainings were met." Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation</p>	05/11/2012			

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	<p>subjects listed and be entered on and be in good standing on the state aide registry. 2) Forte HHC shall maintain documentation, which demonstrate that the requirements of the specified trainings were met."</p> <p>2. During interview on 4/13/12 at 1:30 PM, employee B indicated the skills competency observations for the Home Health Aides are done with the supervisory visits and the skills observed are what the Aides have marked as being done on that day. Any skills observations with a home visit are documented on the supervisory visit line. During training the skills are taught and evaluated by verbal return demonstration and observation on a person in the training room and they only watch the aides do a sponge bath.</p> <p>3. Personnel file F, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation.</p> <p>A. On 4/13/12 at 10:50 AM, employee B indicated that employee F was checked off for skills, but did not complete the test or training for Home Health Aide since employee F was a Certified Nursing Assistant and they complete 150 hours of training versus a Home Health Aide who only completes 75 hours.</p>		<p>checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the</p>				

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	<p>B. On 4/13/12 at 1:15 PM, employee B indicated they let employee F test out of the book work for Home Health Aide since the employee was already a Certified Nursing Assistant but the employee completed the 16 hours of instruction and skills check offs all in one day. Employee B also indicated they had asked questions of employee F using Nurse Aide Training Program Curriculum material in lieu of a written test.</p> <p>3. Personnel file G, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation.</p> <p>A. The Skill Instruction and Observation sheets dated 1/19/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>B. Clinical record #12 evidenced Employee G, first patient contact date 3/2/12, was assigned to patient #12 and provided a shower and "shaved legs and armpits" on 3/2, 3/16, 3/23, 3/30, and 4/6/12. On 3/9/12, a shower was provided. Skills / Observation sheet in file failed to evidence shaving of legs and underarm was competency tested.</p>		<p>requirements have been met. That documentation will be stored in the employee's permanent personnel file. All elements of the standard will be monitored during supervisory visits. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 2. During interview on 4/13/12 at 1:30 PM, employee B indicated the skills competency observations for the Home Health Aides are done with the supervisory visits and the skills observed are what the Aides have marked as being done on that day. Any skills observations with a home visit are documented on the supervisory visit line. During training the skills are taught and evaluated by verbal return demonstration and observation on a person in the training room and they only watch the aides do a sponge bath. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction"</p>				

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	<p>4. Personnel file I, date of hire 2/22/12, indicates the 16 hours of classroom training and Skills Assessment Training / Observation were completed on 2/20/12.</p> <p>A. The Skill Instruction and Observation sheets dated 2/20/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>B. Clinical record #6 evidenced Employee I, first patient contact date 2/22/12, provided a tub bath on 2/22, 2/29, and 3/5/12. Skills observation was not documented until 3/7/12.</p> <p>5. Personnel file J, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>6. Personnel file L, date of hire 1/23/12,</p>		<p>because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. Personnel file F, date of hire 1/19/12, failed to evidence a home health aide completed</p>				

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	<p>failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>7. Personnel file M, date of hire 2/14/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 2/14/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>8. Personnel file N, date of hire 3/20/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 3/5/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>9. Personnel file O, date of hire 1/23/12, failed to evidence a completed home</p>		<p>competency evaluation. A. On 4/13/12 at 10:50 AM, employee B indicated that employee F was checked off for skills, but did not complete the test or training for Home Health Aide since employee F was a Certified Nursing Assistant and they complete 150 hours of training versus a Home Health Aide who only completes 75 hours. B. On 4/13/12 at 1:15 PM, employee B indicated they let employee F test out of the book work for Home Health Aide since the employee was already a Certified Nursing Assistant but the employee completed the 16 hours of instruction and skills check offs all in one day. Employee B also indicated they had asked questions of employee F using Nurse Aide Training Program Curriculum material in lieu of a written test. Plan of Correction: Employee F is no longer providing Home Health Aide services as of 4/16/12, due to not having Home Health Aide status in the state registry, and was informed by A. Doctor RN,MS,MSN,FNP. Employee F was informed that when she has completed the state requirements for home health aide training and submitted the proper documentation and skills validation she may return as an employee. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. Personnel file G, date of hire 1/19/12, failed to evidence a home health aide completed</p>				

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	<p>health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>Clinical record #4 evidenced Employee O, first patient contact date 2/22/12, was assigned to provide care to the patient and provided a shower on 2/25, 2/29, 3/14, 3/21, and 4/4/12.</p> <p>10. During home visit with patient #6 on 4/12/12 at 8:30 AM, employee B indicated when they do supervisory visits with observation of skills to watch to the Aides do personal care with clients, they (employee B) give the patients their privacy and just listen outside the room as the Aide describes what they are doing.</p> <p>11. On 4/13/12 at 1:45 PM 1:45 PM, employee B indicated that employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were already on the Home Health Aide Registry so the agency figured that was all they needed to prove competency testing.</p>		<p>competency evaluation. A. The Skill Instruction and Observation sheets dated 1/19/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee B misunderstood the question by surveyor concerning aidesreceiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. All home health aides will be observed and competency evaluated for bathing (tub, shower, and bed) and shampoo (sink, tub, or bed) by A. Frazier, RN, BSN Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. Clinical record #12 evidenced Employee G, first patient contact date 3/2/12, was</p>				

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			assigned to patient #12 and provided a shower and "shaved legs and armpits" on 3/2, 3/16, 3/23, 3/30, and 4/6/12. On 3/9/12, a shower was provided. Skills / Observation sheet in file failed to evidence shaving of legs and underarm was competency tested. Plan of Correction: Employee G instructed to not do any shaving of patient and to follow nursing plan of care on 4/26/12. All home health aides will be instructed to follow nursing plan of care and not perform any skills they have not been competency evaluated for by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 4. Personnel file I, date of hire 2/22/12, indicates the 16 hours of classroom training and Skills Assessment Training / Observation were completed on 2/20/12. Plan of Correction: The form presented to the surveyor demonstrated that instruction was verified during home health aide training. See attached 16 hours skills assessment training completion form. Assessment completed by Belinda Blosser, RN. A. The Skill Instruction and Observation sheets dated 2/20/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee B		

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			<p>misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored</p>		

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			in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. Clinical record #6 evidenced Employee I, first patient contact date 2/22/12, provided a tub bath on 2/22, 2/29, and 3/5/12. Skills observation was not documented until 3/7/12. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home				

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			Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. On 2/22/12 employee I was observed to complete bath by B. Blosser, RN. See attachment. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 5. Personnel file J, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee J was terminated on 3/15/12. All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The	

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			<p>training and testing will be administered by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 6. Personnel file L, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide</p>		

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			<p>Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 7. Personnel file M, date of hire 2/14/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 2/14/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees who were trained by the agency, had already received</p>		

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			<p>their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 8. Personnel file N, date of hire 3/20/12, failed to evidence</p>		

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			a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 3/5/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency		

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NAME OF PROVIDER OR SUPPLIER FORTE HOME HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 808 A SOUTH HUNTINGTON STREET SYRACUSE, IN 46567
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			validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 9. Personnel file O, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Clinical record #4 evidenced Employee O, first patient contact date 2/22/12, was assigned to provide care to the patient and provided a shower on 2/25, 2/29, 3/14, 3/21, and 4/4/12. Plan of Correction: Employee B	

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			<p>misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo,</p>		

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			<p>sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 10. During home visit with patient #6 on 4/12/12 at 8:30 AM, employee B indicated when they do supervisory visits with observation of skills to watch to the Aides do personal care with clients, they (employee B) give the patients their privacy and just listen outside the room as the Aide describes what they are doing. Plan of Correction: This statement is incorrect. Employee B was referencing standing outside the patient's room and listening/observing while the patient was getting ready for bath and shower was observed. This is in respect for patient's privacy. While it is the policy of Forte HHC to treat each patient with respect and dignity by limiting the number of people in the room while the patient is being undressed and prepared for bathing, supervisory visits will now be conducted within direct sight of patient and employee effective 4/16/12. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 11. On 4/13/12 at 1:45 PM 1:45 PM, employee B indicated that employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were already on the Home Health Aide</p>	

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			<p>Registry so the agency figured that was all they needed to prove competency testing. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health</p>		

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			Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training/competency validation to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc		

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N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, policy review, and interview, the agency failed to ensure the employees were following infection control practices for 4 of 5 home visit observations with the potential to affect all the agency's patients. (#2, 3, 5, and 6).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During home visit for patient #2 on 4/11/12 at 2:45 PM, employee B was not observed to have washed hands or use hand gel prior to assessing patient and did not clean blood pressure cuff or stethoscope prior to or after use. 2. During home visit for patient #3 on 4/11/12 at 3:30 PM, employee B was not observed to have washed hands or use hand gel prior to assessing patient and did not clean blood pressure cuff or stethoscope prior to or after use. 3. During home visit for patient #5 on 4/13/12 at 11:25 AM, employee B was not observed to have washed hands or use hand gel prior to assessing patient and did 	N0470	<ol style="list-style-type: none"> 1. During home visit for patient #2 on 4/11/12 at 2:45 PM, employee B was not observed to have washed hands or use hand gel prior to assessing patient and did not clean blood pressure cuff or stethoscope prior to or after use. Plan of Correction: Employee B cleaned BP cuff, stethoscope with alcohol wipes in car prior to entering residence. Employee B used hand sanitizer in car prior to entering and leaving homes. This was not observed by the surveyor. A policy has been created for cleaning Medical Equipment and Devices. See Cleaning Medical Equipment and Devices policy in attachment. All staff will be in-services and required to review policy to ensure the deficiency does not recur. The above corrections will be supervised by A. Frazier, RN, BSN. This technique will be reviewed annually in the Continuing Education training curriculum and observed by nursing supervisor during supervisory visits. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 2. During home visit for patient #3 on 4/11/12 at 3:30PM, employee B was not observed to 	05/11/2012			

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	<p>not clean blood pressure cuff or stethoscope prior to or after use.</p> <p>4. During home visit for patient #6 on 4/12/12 at 8:30 AM, Home Health Aide (employee I) was observed providing a tub bath to patient. Employee I did not wash hands prior to donning gloves. After washing the patient's hair and handling the shower sprayer, the Aide provided oral care with a toothbrush but did not change gloves prior to performing the task. The Aide continued the bath with the same pair of gloves and did not change gloves when dressing the patient. The Aide was not observed to have washed the patient's back or perineal area.</p> <p>On 4/12/12 at 1:05 PM, employee B indicated the aide did not wash hands prior to putting on gloves because the aide has eczema, and the aid reported they washed their hands after care was done and patient was in living room with family.</p> <p>5. On 4/11/12 at 3:55 PM, employee B indicated they use hand sanitizer and also clean the equipment used on patients while driving to the next visit.</p> <p>6. On 4/12/12 at 10:20 AM, employee B indicated the agency uses the Lippincott Manual of Nursing Practice for the</p>		<p>have washed hands or use hand gel prior to assessing patient and did not clean blood pressure cuff or stethoscope prior to or after use. Plan of Correction: Employee B cleaned BP cuff, stethoscope with alcohol wipes in car prior to entering residence. Employee B used hand sanitizer in car prior to entering and leaving homes. This was not observed by the surveyor. A policy has been created for cleaning Medical Equipment and Devices which will be implemented. See Cleaning Medical Equipment and Devices policy in attachment. All staff will be notified and required to review policy to ensure the deficiency does not recur. The above corrections will be supervised by A. Frazier, RN, BSN. This technique will be reviewed annually in the Continuing Education training curriculum and observed by nursing supervisor during supervisory visits. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. During home visit for patient #5 on 4/13/12 at 11:25AM, employee B was not observed to have washed hands or use hand gel prior to assessing patient and did not clean blood pressure cuff or stethoscope prior to or after use. Plan of Correction: Employee B cleaned BP cuff, stethoscope with alcohol wipes in car prior to entering residence. Employee B used hand sanitizer in car prior to</p>				

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	clinical procedure policies. Employee B looked up toothbrush procedure and indicated the book did not include the need to use gloves.		entering and leaving homes. This was not observed by the surveyor. A policy has been created for cleaning Medical Equipment and Devices which will be implemented . See Cleaning Medical Equipment and Devices policy in attachment. All staff will be notified and required to review policy to ensure the deficiency does not recur. The above corrections will be supervised by A. Frazier, RN, BSN. This technique will be reviewed annually in the Continuing Education training curriculum and observed by nursing supervisor during supervisory visits. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 4. During home visit for patient #6 on 4/12/12 at 8:30 AM, Home Health Aide (employee I) was observed providing a tub bath to patient. Employee I did not wash hands prior to donning gloves. After washing the patient's hair and handling the shower sprayer, the Aide provided oral care with a toothbrush but did not change gloves prior to performing the task. The Aide continued the bath with the same pair of gloves and did not change gloves when dressing the patient. The Aide was not observed to have washed the patient's back or perineal area. Plan of Correction: Employee I and all employees will be re-instructed and required to review policies of the facility regarding Proper Glove Use (see		

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			<p>Proper Glove Use policy in attachment) practices to ensure the deficiency does not recur. This technique will be reviewed annually in the Continuing Education training curriculum and observed by nursing supervisor during supervisory visits. Employee I was re-instructed on proper bathing techniques on 4/16/12 by A. Doctor RN, MA, MSN, FNP-Bc and will have skills verification by A. Frazier RN, BSN. Employee I has been instructed if for any medical reason she cannot wash her hands prior to putting on gloves a physician's note must be presented. The above corrections will be supervised by A. Frazier, RN, BSN.</p> <p>Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 5. On 4/11/12 at 3:55 PM, employee B indicated they use hand sanitizer and also clean the equipment used on patients while driving to the next visit. Plan of Correction: Employee B cleaned BP cuff, stethoscope with alcohol wipes in car prior to entering residence. Employee B used hand sanitizer in car prior to entering and leaving homes. This was not observed by the surveyor. A policy has been created for cleaning Medical Equipment and Devices which will be implemented May 1, 2012. See Cleaning Medical Equipment and Devices policy in attachment. All staff will be notified and required</p>		

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			to review policy by May 11, 2012 to ensure the deficiency does not recur. The above corrections will be supervised by A. Frazier, RN, BSN. This technique will be reviewed annually in the Continuing Education training curriculum This technique will be reviewed annually in the Continuing Education training curriculum and observed by nursing supervisor during supervisory visits. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 6. On 4/12/12 at 10:20 AM, employee B indicated the agency uses the Lippincott Manual of Nursing Practice for the clinical procedure policies. Employee B looked up toothbrush procedure and indicated the book did not include the need to use gloves. Plan of Correction: Employee I and all employees will be re-instructed and required to review policies of the facility regarding Proper Glove Use (see Proper Glove Use policy in attachment) practices to ensure the deficiency does not recur. This technique will be reviewed annually in the Continuing Education training curriculum and observed by nursing supervisor during supervisory visits. The above corrections will be supervised by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc		

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N0512	<p>410 IAC 17-12-3(b)(4) Patient Rights Rule 12 Sec. 3(b)(4) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (4) The patient has the right to be as follows: (A) Free from verbal, physical, and psychological abuse. (B) Treated with dignity.</p> <p>Based on document and clinical record review and interview, the agency failed to ensure the patient was informed of the right to be free from verbal, physical, and psychological abuse and be treated with dignity for 12 of 12 records reviewed with the potential to affect all the agency's patients. (# 1-12).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The document titled "Client Rights and Responsibilities" failed to evidence the clients have the right to be free from verbal, physical, and psychological abuse and treated with dignity. 2. Records 1-12 evidenced the patients received the patient rights document. 3. On 4/11/12 at 12:00 PM, employee B indicated the document failed to evidence the patient's right to be free from verbal, physical, and psychological abuse and be treated with dignity. 	N0512	<p>1. The document titled "Client Rights and Responsibilities" failed to evidence the clients have the right to be free from verbal, physical, and psychological abuse and treated with dignity. Plan of correction: This deficiency was corrected on April 13, 2012, and proved to surveyor. Revised copies will be signed by the patient or representative by 5/11/12 for all current patients. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 2. Records 1-12 evidenced the patient rights document. Plan of correction: This deficiency was corrected on April 13, 2012, and proved to surveyor. Revised copies will be signed by the patient or representative by 5/11/12 for all current patients. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. On 4/11/12 at 12:00 PM, employee B indicated the document failed to evidence the patient's right to be free from verbal, physical, and psychological abuse and be treated with dignity. Plan of</p>	05/11/2012			

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			correction: This deficiency was corrected on April 13, 2012, and proved to surveyor. Revised copies will be signed by the patient or representative by 5/11/12 for all current patients. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc		

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N0516	<p>410 IAC 17-12-3(d) Patient Rights Rule 12 Sec. 3(d) (d) The home health agency shall make available to the patient upon request, a written notice in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment, a listing of all individuals or other legal entities who have an ownership or control interest in the agency as defined in 42 CFR § 420.201, 42 CFR § 420.202, and 42 CFR § 420.206, in effect on July 1, 2005.</p> <p>Based on document and clinical record review and interview, the agency failed to ensure the patient was informed of the right to request a listing of all individuals or other legal entities who have an ownership or control interest in the agency for 12 of 12 records reviewed with the potential to affect all the agency's patients. (# 1-12).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The document titled "Client Rights and Responsibilities" failed to evidence the clients were informed of the right to request a listing of all individuals or other legal entities who have an ownership or control interest in the agency. 2. Records 1-12 evidenced the patients received the patient rights document. 3. On 4/11/12 at 12:00 PM, employee B 	N0516	<ol style="list-style-type: none"> 1. The document titled "Client Rights and Responsibilities" failed to evidence the clients have the right to be free from verbal, physical, and psychological abuse and treated with dignity. Plan of correction: This deficiency was corrected on April 13, 2012, and proved to surveyor. Revised copies will be signed by the patient or representative by 5/11/12 for all current patients. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 2. Records 1-12 evidenced the patients received the patient rights document. Plan of correction: This deficiency was corrected on April 13, 2012, and proved to surveyor. Revised copies will be signed by the patient or representative by 5/11/12 for all current patients. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. On 4/11/12 at 12:00 PM, employee B indicated the document failed to evidence the patient's right to be free from verbal, physical, and 	05/11/2012			

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	indicated the document failed to evidence the right to request a listing of all individuals or other legal entities who have an ownership or control interest in the agency.		psychological abuse and be treated with dignity. Plan of correction: This deficiency was corrected on April 13, 2012, and proved to surveyor. Revised copies will be signed by the patient or representative by 5/11/12 for all current patients. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc		

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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 review, policy review, observation, and interview, the agency failed to ensure the durable medical equipment was listed on the Plan of Care and the certification periods were for a 60 day period for 12 of 12 records reviewed with the potential to affect all the agency's 12 patients. (#1-12)</p> <p>Findings include:</p> <p>1. Clinical record #1 contained a plan of</p>	N0524	<p>1. Clinical record #1 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. Plan of Correction: Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. Recertification dates have been corrected on forms according to policy by A. Doctor RN, MA, MSN, FNP-Bc. The orders signed by physician were</p>	05/11/2012			

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	<p>care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12.</p> <p>A. Start of Care date is listed as 2/20/12. The physician order to "Assess client for home health care" is dated 2/21/12. The Comprehensive Assessment, Consent to Receive Services, Release of Information, and Service Relationship Agreement forms are dated 2/21/12.</p> <p>B. The Home Safety Checklist, General Health Assessment, and Progress Notes are dated 2/20/12.</p> <p>C. The record evidenced a physician order to "encourage movement & activities" dated 2/21/12. This order was not listed on the plan of care.</p> <p>2. Clinical record #2 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12.</p> <p>A. A second certification period was started on 3/5/12 when Skilled Nursing services was added, the certification period listed is 3/5/12 - 5/4/12. The certification period beginning 3/5/12</p>		<p>for 60 days, so were correct orders. The dates will be verified by the supervising nurse and office personnel responsible for faxing and filing. Errors were corrected on 4/27/12 according to policy. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p> <p>A. Start of Care date is listed as 2/20/12. The physician order to "Assess client for home health care" is dated 2/21/12. The Comprehensive Assessment, Consent to Receive Services, Release of Information, and Service Relationship Agreement forms are dated 2/21/12. Plan of Correction: Errors were corrected on 4/27/12 according to policy. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p> <p>B. The Home Safety Checklist, General Health Assessment, and Progress Notes are dated 2/20/12. Plan of Correction: Errors were corrected on 4/27/12 according to policy. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p> <p>C. The record evidenced a physician order to "encourage movement & activities" dated 2/21/12. This order was not listed on the plan of care. Plan of Correction: The patient has been discharged. Future orders will be verified on Nursing Plan of Care. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p> <p>2. Clinical record #2 contained a plan of care for the certification period 2/20/12 - 4/1/12. The</p>				

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	<p>should have ended on 5/3/12.</p> <p>B. Physician orders to "Assess client for home health care" is dated 2/21/12. The client Medication List is dated 2/18/12, and Progress Notes are dated 2/20/12.</p> <p>C. On 4/11/12 at 2:45 PM during home visit, a wheel chair was seen in the home. Wheelchair is not listed under durable medical equipment and supplies on the plan of care. The client's family member and employee B indicated the wheelchair belonged to the client.</p> <p>3. Clinical record #3 contained a plan of care for the certification period 3/8/12 - 4/7/12. The certification period beginning 3/8/12 should have ended on 5/6/12. On 4/11/12 at 3:30 PM, during home visit, the patient was observed to be sitting in a wheelchair. The wheelchair is not specified on the plan of care.</p> <p>4. Clinical record #4 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/15/12 when Skilled Nursing services was added. The certification period listed is 3/15/12 - 5/14/12. The certification period beginning 3/15/12 should have</p>		<p>certification period beginning 2/20/12 should have ended on 4/19/12. Plan of Correction: Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager on 4/14/12. Recertification dates have been corrected on forms according to policy by A. Doctor RN, MA, MSN, FNP-Bc. The orders signed by physician were for 60 days, so were correct orders. The dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc A. A second certification period was started on 3/5/12 when Skilled Nursing services was added, the certification period listed is 3/5/12 - 5/4/12. The certification period beginning 3/5/12 should have ended on 5/3/12. Plan of Correction: The dates were corrected on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager by 4/14/12. The dates will be verified by the supervising nurse and office personnel responsible for faxing and filing. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. Physician orders to "Assess client for home health care" is dated 2/21/12. The client</p>				

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	<p>ended on 5/13/12.</p> <p>5. Clinical record #5 contained a plan of care for the certification period 3/27/12 - 5/26/12. The certification period beginning 3/27/12 should have ended on 5/25/12.</p> <p>6. Clinical record #6 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/5/12 when Skilled Nursing services was added. The certification period listed is 3/5/12 - 5/4/12. The certification period beginning 3/5/12 should have ended on 5/3/12. On 4/12/12 at 8:30 AM during home visit, the client was observed to be in a wheelchair. The wheelchair is not listed on the plan of care.</p> <p>7. Clinical record #7 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/20/12 when Skilled Nursing services was added, the certification period listed is 3/20/12 - 5/19/12. The certification period beginning 3/20/12 should have ended on 5/18/12.</p>		<p>Medication List is dated 2/18/12, and Progress Notes are dated 2/20/12. Plan of Correction: The dates were corrected according to policy on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc C. On 4/11/12 at 2:45 PM during home visit, a wheel chair was seen in the home. Wheelchair is not listed under durable medical equipment and supplies on the plan of care. The client's family member and employee B indicated the wheelchair belonged to the client. Plan of Correction: Wheelchair was added to the plan of care on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Future assessments will include all durable medical equipment. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. Clinical record #3 contained a plan of care for the certification period 3/8/12 - 4/7/12. The certification period beginning 3/8/12 should have ended on 5/6/12. On 4/11/12 at 3:30 PM, during home visit, the patient was observed to be sitting in a wheelchair. The wheelchair is not specified on the plan of care. Plan of Correction: The dates were corrected according to policy on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office</p>				

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	<p>8. Clinical record #8 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/13/12 when Skilled Nursing services was added, the certification period listed is 3/13/12 - 5/12/12. The certification period beginning 3/13/12 should have ended on 5/11/12.</p> <p>9. Clinical record #9 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/5/12 when Skilled Nursing services was added, the certification period listed is 3/5/12 - 5/4/12. The certification period beginning 3/5/12 should have ended on 5/3/12.</p> <p>10. Clinical record #10 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12.</p> <p>11. Clinical record #11 contained a plan of care for the certification period 3/27/12 -5/26/12. The certification period</p>		<p>manager. The dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Wheelchair has been added to the plan of care by A. Doctor RN, MA, MSN, FNP-Bc. Future assessments will include all durable medical equipment. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 4. Clinical record #4 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/15/12 when Skilled Nursing services was added. The certification period listed is 3/15/12 - 5/14/12. The certification period beginning 3/15/12 should have ended on 5/13/12. Plan of Correction: The dates were corrected according to policy on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. The dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 5. Clinical record #5 contained a plan of care for the certification period 3/27/12 - 5/26/12. The certification period beginning 3/27/12 should have ended on</p>				

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	<p>beginning 3/27/12 should have ended on 5/25/12.</p> <p>12. Clinical record #12 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12.</p> <p>13. The agency's policy titled "Medical Plan of Care" #5.1, not dated, states "The plan of care shall include: ... 2) The services to be furnished and equipment required."</p> <p>14. During interview on 4/11/12 at 12:55 PM, employee B indicated the dates for clinical records #1 and #2 were mis-dated and services were provided on 2/20, not 2/21. The physician orders should also be dated 2/20. Also the medication list for clinical record #2 was received on the date indicated as the agency received the list early, before care was provided.</p>		<p>5/25/12. Plan of Correction: The dates were corrected according to policy on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. The dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc.</p> <p>6. Clinical record #6 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/5/12 when Skilled Nursing services was added. The certification period listed is 3/5/12 - 5/4/12. The certification period beginning 3/5/12 should have ended on 5/3/12. On 4/12/12 at 8:30 AM during home visit, the client was observed to be in a wheelchair. The wheelchair is not listed on the plan of care. Plan of Correction: The dates were corrected according to policy on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. The dates will be verified by the supervising nurse and office personnel responsible</p>				

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			for faxing and filing prior to sending. Wheelchair has been added to the plan of care by A. Doctor RN, MA, MSN, FNP-Bc. Future assessments will include all durable medical equipment. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 7. Clinical record #7 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/20/12 when Skilled Nursing services was added, the certification period listed is 3/20/12 - 5/19/12. The certification period beginning 3/20/12 should have ended on 5/18/12. Plan of Correction: The dates were corrected according to policy on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. The dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 8. Clinical record #8 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/13/12 when Skilled Nursing services		

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			<p>was added, the certification period listed is 3/13/12 - 5/12/12. The certification period beginning 3/13/12 should have ended on 5/11/12. Plan of Correction: The dates were corrected according to policy on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. The dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 9. Clinical record #9 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. A second certification period was started on 3/5/12 when Skilled Nursing services was added, the certification period listed is 3/5/12 - 5/4/12. The certification period beginning 3/5/12 should have ended on 5/3/12. Plan of Correction: The dates were corrected according to policy on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. The dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to</p>	

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			<p>sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 10. Clinical record #10 contained a plan of care for the certification period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. Plan of Correction: The dates were corrected according to policy on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. The dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 11. Clinical record #11 contained a plan of care for the certification period 3/27/12 -5/26/12. The certification period beginning 3/27/12 should have ended on 5/25/12. Plan of Correction: The dates were corrected according to policy on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. The dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 12. Clinical record #12 contained a plan of care for the certification</p>		

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			<p>period 2/20/12 - 4/1/12. The certification period beginning 2/20/12 should have ended on 4/19/12. Plan of Correction: The dates were corrected according to policy on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. Agency has downloaded the "OASIS Follow-up Assessment Scheduling Calendar" for reference by C. Gaham, office manager. The dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 13. The agency's policy titled "Medical Plan of Care" #5.1, not dated, states "The plan of care shall include: ... 2) The services to be furnished and equipment required." Plan of Correction: Future assessments will include a survey of all durable medical equipment to be assured that it is listed on the plan of care. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 14. During interview on 4/11/12 at 12:55 PM, employee B indicated the dates for clinical records #1 and #2 were mis-dated and services were provided on 2/20, not 2/21. The physician orders should also be dated 2/20. Also the medication list for clinical record #2 was received on the date indicated as the agency received the list early, before care was provided. Plan of Correction: The dates were</p>		

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			corrected according to policy on 4/27/12 by A. Doctor RN, MA, MSN, FNP-Bc. All dates will be verified by the supervising nurse and office personnel responsible for faxing and filing prior to sending. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc		

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N0550	<p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on clinical record review, observation during home visits, policy review, and interview, the agency failed to ensure the home health aides received written plans of care for the clients for 9 of 12 records reviewed of patients receiving home health aide services with the potential to affect all of the agency's patients receiving home health aide services. (#1, 2, 4, 6, 7, 8, 9, 10, and 12).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical records #1, 2, 4, 6, 7, 8, 9, 10, and 12 failed to evidence a Home Health Aide Care Plan. During home visit to patient #6 on 4/12/12 at 8:30 AM, the record in the home failed to evidence a home health aide care plan. 2. On 4/11/11 at 1:05 PM, employee B indicated the Plan of Care is used as the aide care plan. 3. The agency's policy titled "Assignment and Duties of the Home Health Aide," 	N0550	<ol style="list-style-type: none"> 1. Clinical records #1, 2, 4, 6, 7, 8, 9, 10, and 12 failed to evidence a Home Health Aide Care Plan. During home visit to patient #6 on 4/12/12 at 8:30 AM, the record in the home failed to evidence a home health aide care plan. Plan of Correction: Although no regulation states that the physician plan of care cannot also be utilized as a multidisciplinary plan of care, including home health services, Forte HHC has implemented a Nursing Plan of Care for all patient records. This Plan of Care form was completed by A. Doctor, RN, MA, MSN, FNP-Bc on 4/27/12 and can be found in the attachment document as form Nursing Plan of Care. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 2. On 4/11/11 at 1:05 PM, employee B indicated the Plan of Care is used as the aide care plan. Plan of Correction: Although no regulation states that the physician plan of care cannot also be utilized as a multidisciplinary plan of care, including home health services, Forte HHC has implemented a 	05/11/2012			

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	#7.8, not dated, states, "The home health aide is assigned to a specific client by the registered nurse. Written client care instructions for the home health aide must be prepared by the registered nurse / nursing supervisor who is responsible for the supervision of the home health aide."		Nursing Plan of Care for all patient records. This Plan of Care form was completed by A. Doctor, RN, MA, MSN, FNP-Bc on 4/27/12 and can be found in the attachment document as form Nursing Plan of Care. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. The agency's policy titled "Assignment and Duties of the Home Health Aide," #7.8, not dated, states, "The home health aide is assigned to a specific client by the registered nurse. Written client care instructions for the home health aide must be prepared by the registered nurse / nursing supervisor who is responsible for the supervision of the home health aide." Plan of Correction: Although no regulation states that the physician plan of care cannot also be utilized as a multidisciplinary plan of care, including home health services, Forte HHC has implemented a Nursing Plan of Care for all patient records. This Plan of Care form was completed by A. Doctor, RN, MA, MSN, FNP-Bc on 4/27/12 and can be found in the attachment document as form Nursing Plan of Care. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc				

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N0596	<p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and</p> <p>Based on document review, clinical record review, interview, and policy review, the agency failed to ensure Home Health Aides completed a competency evaluation prior to patient care for 7 of 9 home health aide files reviewed with the potential to affect all the patients receiving home health aide services. (employees F, G, I, J, L, N, and O).</p> <p>Findings include:</p> <p>1. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program that addresses each of the subjects listed and be entered on and be in</p>	N0596	<p>1. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program that addresses each of the subjects listed and be entered on and be in good standing on the state aide registry. 2) Forte HHC shall maintain documentation, which demonstrate that the requirements of the specified trainings were met." Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as</p>	05/11/2012			

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	<p>good standing on the state aide registry. 2) Forte HHC shall maintain documentation, which demonstrate that the requirements of the specified trainings were met."</p> <p>2. During interview on 4/13/12 at 1:30 PM, employee B indicated the skills competency observations for the Home Health Aides are done with the supervisory visits and the skills observed are what the Aides have marked as being done on that day. Any skills observations with a home visit are documented on the supervisory visit line. During training the skills are taught and evaluated by verbal return demonstration and observation on a person in the training room and they only watch the aides do a sponge bath.</p> <p>3. Personnel file F, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation.</p> <p>A. On 4/13/12 at 10:50 AM, employee B indicated that employee F was checked off for skills, but did not complete the test or training for Home Health Aide since employee F was a Certified Nursing Assistant and they complete 150 hours of training versus a Home Health Aide who only completes 75 hours.</p> <p>B. On 4/13/12 at 1:15 PM, employee</p>		evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that				

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	<p>B indicated they let employee F test out of the book work for Home Health Aide since the employee was already a Certified Nursing Assistant but the employee completed the 16 hours of instruction and skills check offs all in one day. Employee B also indicated they had asked questions of employee F using Nurse Aide Training Program Curriculum material in lieu of a written test.</p> <p>3. Personnel file G, date of hire 1/19/12, failed to evidence a home health aide completed competency evaluation.</p> <p>A. The Skill Instruction and Observation sheets dated 1/19/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>B. Clinical record #12 evidenced Employee G, first patient contact date 3/2/12, was assigned to patient #12 and provided a shower and "shaved legs and armpits" on 3/2, 3/16, 3/23, 3/30, and 4/6/12. On 3/9/12, a shower was provided. Skills / Observation sheet in file failed to evidence shaving of legs and underarm was competency tested.</p>		<p>goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. All elements of the standard will be monitored during supervisory visits. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 2. During interview on 4/13/12 at 1:30 PM, employee B indicated the skills competency observations for the Home Health Aides are done with the supervisory visits and the skills observed are what the Aides have marked as being done on that day. Any skills observations with a home visit are documented on the supervisory visit line. During training the skills are taught and evaluated by verbal return demonstration and observation on a person in the training room and they only watch the aides do a sponge bath. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has</p>				

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	<p>4. Personnel file I, date of hire 2/22/12, indicates the 16 hours of classroom training and Skills Assessment Training / Observation were completed on 2/20/12.</p> <p>A. The Skill Instruction and Observation sheets dated 2/20/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>B. Clinical record #6 evidenced Employee I, first patient contact date 2/22/12, provided a tub bath on 2/22, 2/29, and 3/5/12. Skills observation was not documented until 3/7/12.</p> <p>5. Personnel file J, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>6. Personnel file L, date of hire 1/23/12, failed to evidence a completed home</p>		<p>signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. Personnel file F, date of hire 1/19/12, failed to evidence</p>				

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	<p>health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>7. Personnel file M, date of hire 2/14/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 2/14/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>8. Personnel file N, date of hire 3/20/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 3/5/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>9. Personnel file O, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The</p>		<p>a home health aide completed competency evaluation. A. On 4/13/12 at 10:50 AM, employee B indicated that employee F was checked off for skills, but did not complete the test or training for Home Health Aide since employee F was a Certified Nursing Assistant and they complete 150 hours of training versus a Home Health Aide who only completes 75 hours. B. On 4/13/12 at 1:15 PM, employee B indicated they let employee F test out of the book work for Home Health Aide since the employee was already a Certified Nursing Assistant but the employee completed the 16 hours of instruction and skills check offs all in one day. Employee B also indicated they had asked questions of employee F using Nurse Aide Training Program Curriculum material in lieu of a written test. Plan of Correction: Employee F is no longer providing Home Health Aide services as of 4/16/12, due to not having Home Health Aide status in the state registry, and was informed by A. Doctor RN,MS,MSN,FNP. Employee F was informed that when she has completed the state requirements for home health aide training and submitted the proper documentation and skills validation she may return as an employee. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. Personnel file G, date of hire 1/19/12, failed to evidence</p>				

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	<p>Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed.</p> <p>Clinical record #4 evidenced Employee O, first patient contact date 2/22/12, was assigned to provide care to the patient and provided a shower on 2/25, 2/29, 3/14, 3/21, and 4/4/12.</p> <p>10. During home visit with patient #6 on 4/12/12 at 8:30 AM, employee B indicated when they do supervisory visits with observation of skills to watch to the Aides do personal care with clients, they (employee B) give the patients their privacy and just listen outside the room as the Aide describes what they are doing.</p> <p>11. On 4/13/12 at 1:45 PM 1:45 PM, employee B indicated that employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were already on the Home Health Aide Registry so the agency figured that was all they needed to prove competency testing.</p>		<p>a home health aide completed competency evaluation. A. The Skill Instruction and Observation sheets dated 1/19/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee B misunderstood the question by surveyor concerning aidesreceiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. All home health aides will be observed and competency evaluated for bathing (tub, shower, and bed) and shampoo (sink, tub, or bed) by A. Frazier, RN, BSN Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. Clinical record #12 evidenced Employee G, first</p>				

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			<p>patient contact date 3/2/12, was assigned to patient #12 and provided a shower and "shaved legs and armpits" on 3/2, 3/16, 3/23, 3/30, and 4/6/12. On 3/9/12, a shower was provided. Skills / Observation sheet in file failed to evidence shaving of legs and underarm was competency tested. Plan of Correction: Employee G instructed to not do any shaving of patient and to follow nursing plan of care on 4/26/12. All home health aides will be instructed to follow nursing plan of care and not perform any skills they have not been competency evaluated for by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 4. Personnel file I, date of hire 2/22/12, indicates the 16 hours of classroom training and Skills Assessment Training / Observation were completed on 2/20/12. Plan of Correction: The form presented to the surveyor demonstrated that instruction was verified during home health aide training. See attached 16 hours skills assessment training completion form. Assessment completed by Belinda Blosser, RN. A. The Skill Instruction and Observation sheets dated 2/20/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan</p>		

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			of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met.		

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			That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc B. Clinical record #6 evidenced Employee I, first patient contact date 2/22/12, provided a tub bath on 2/22, 2/29, and 3/5/12. Skills observation was not documented until 3/7/12. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training				

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			<p>deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. On 2/22/12 employee I was observed to complete bath by B. Blosser, RN. See attachment. Employees will not be allowed to perform tasks without being observed and competency tested. Skills competency will be verified in home health aide training by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 5. Personnel file J, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee J was terminated on 3/15/12. All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and</p>	

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NAME OF PROVIDER OR SUPPLIER FORTE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 808 A SOUTH HUNTINGTON STREET SYRACUSE, IN 46567		
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			complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 6. Personnel file L, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Forte Home Health Care has contracted with Amy		

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			Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 7. Personnel file M, date of hire 2/14/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 2/14/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees who were trained by		

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			<p>the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 8. Personnel file N, date</p>		

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			of hire 3/20/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 3/5/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide		

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			Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. All home health aides will receive competency training on sponge, tub, and shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 9. Personnel file O, date of hire 1/23/12, failed to evidence a completed home health aide competency evaluation. The Skill Instruction and Observation sheets dated 1/23/12 list instruction / observation for "Sponge, tub, or shower bath" and also "Shampoo, sink, tub, or bed." There are no markings to indicate instruction / observation of which of these skills were instructed and/or observed. Clinical record #4 evidenced Employee O, first patient contact date 2/22/12, was assigned to provide care to the patient and provided a shower on 2/25, 2/29, 3/14, 3/21, and 4/4/12. Plan of		

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			<p>Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. All home health aides will receive competency training on sponge, tub, and</p>		

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			<p>shower bath, and also shampoo, sink, tub, or bed, and complete a written test. The training and testing will be administered by A. Frazier, RN, BSN. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 10. During home visit with patient #6 on 4/12/12 at 8:30 AM, employee B indicated when they do supervisory visits with observation of skills to watch to the Aides do personal care with clients, they (employee B) give the patients their privacy and just listen outside the room as the Aide describes what they are doing. Plan of Correction: This statement is incorrect. Employee B was referencing standing outside the patient's room and listening/observing while the patient was getting ready for bath and shower was observed. This is in respect for patient's privacy. While it is the policy of Forte HHC to treat each patient with respect and dignity by limiting the number of people in the room while the patient is being undressed and prepared for bathing, supervisory visits will now be conducted within direct sight of patient and employee effective 4/16/12. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 11. On 4/13/12 at 1:45 PM 1:45 PM, employee B indicated that employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were</p>		

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			<p>already on the Home Health Aide Registry so the agency figured that was all they needed to prove competency testing. Plan of Correction: Employee B misunderstood the question by surveyor concerning aides receiving 16 hours of skills training. Employee B thought that the surveyor was asking about orientation, not skills validation. Each employee had 16 hours of orientation on 2 different days, as evidenced by their orientation checklist, in the personnel files. Employees verified as being on the home health aide registry were not required and did not receive skills instruction during orientation. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during skills observation. Employees who were trained by the agency, had already received their 16 hours of training during their Home Health Aide program. The home health aide skills validation form has signatures under "instruction" because employee B asked each employee if they had received instruction in each specific requirement during their training. The actual 16 hours of skills instruction this was denoted by an additional form, which were shown to the surveyor and are now attached to the plan of</p>		

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			<p>correction. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide re-instruction for all cited training deficiencies and future Home Health Aide training. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training/competency validation to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p>		

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N0597	<p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry.</p> <p>Based on personnel file review, policy review, and interview, the agency failed to ensure the aide was entered on and in good standing on the state aide registry for 2 of 9 records reviewed with the potential to affect all the agency's patients who receive home health aide services. (employees F and J)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Personnel file F, date of hire 1/19/12, failed to evidence documentation the aide was entered on and in good standing on the State Aide registry. 2. Personnel file J, date of hire 1/23/12, failed to evidence documentation the aide was entered on and in good standing on the State Aide registry. <p>On 4/13/12 at 2:00 PM, employee B indicated the agency had checked employee J's Home Health Aide registry verification but it did not the print the second page which shows the verification.</p> <ol style="list-style-type: none"> 3. The agency's policy titled "Section 7-Home Health Aide Requirements," not 	N0597	<p>Based on personnel file review, policy review, and interview, the agency failed to ensure the aide was entered on and in good standing on the state aide registry for 2 of 9 records reviewed with the potential to affect all the agency's patients who receive home health aide services. (employees F and J) Plan of correction: Office manager or designee will verify presence on the Indiana State Home Health Aide Registry prior to job orientation and add evidence of registry to the aide's personnel file. Registry will be reviewed for renewal as aide's certification period gets close to expiration. The office will also notify aides as renewal date gets close to expiration. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc</p> <p>1. Personnel file F, date of hire 1/19/12, failed to evidence documentation the aide was entered on and in good standing on the State Aide registry. Plan of correction:Employee F was informed effective 4/16/12 that she could no longer provide care until she received home health aide training. Forte Home Health Care will no longer accept certifications of CNA for Home Health Aide positions. Responsible</p>	05/11/2012			

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	dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program that addresses each of the subjects listed and be entered on and be in good standing on the state aide registry."		Person: A. Doctor RN, MA, MSN, FNP-Bc 2. Personnel file J, date of hire 1/23/12, failed to evidence documentation the aide was entered on and in good standing on the State Aide registry. On 4/13/12 at 2:00 PM, employee B indicated the agency had checked employee J's Home Health Aide registry verification but it did not the print the second page which shows the verification. Plan of correction: Employee J was terminated on 3/15/12. Office manager or designee will verify presence on the Indiana State Home Health Aide Registry prior to job orientation and add evidence of registry to the aide's personnel file. Registry will be reviewed for renewal as aide's certification period gets close to expiration. The office will also notify aides as renewal date gets close to expiration. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program that addresses each of the subjects listed and be entered on				

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			and be in good standing on the state aide registry." Plan of correction: Office manager or designee will verify presence on the Indiana State Home Health Aide Registry prior to job orientation and add evidence of registry to the aide's personnel file. Registry will be reviewed for renewal as aide's certification period gets close to expiration. The office will also notify aides as renewal date gets close to expiration. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove competency. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc		

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N0600	<p>410 IAC 17-14-1(l)(3) Scope of Services Rule 14 Sec. 1(l)(3) If the home health agency issuing the proof of the aide's achievement of successful completion of a competency evaluation program is not the employing agency, the employing agency shall keep a copy of the competency evaluation documentation in the home health aide's employment file.</p> <p>Based on personnel file review, policy review, and interview, the agency failed to ensure the personnel files contained a competency evaluation was in the employee's file for 4 of 4 files reviewed of aides who were on the registry. (employees G, J, L, and O)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Personnel file G, a Home Health Aide, date of hire 1/19/12, failed to evidence documentation of Home Health Aide testing. 2. Personnel file J, a Home Health Aide, date of hire 1/23/12, failed to evidence documentation of Home Health Aide testing. 3. Personnel file L, a Home Health Aide, date of hire 1/23/12, failed to evidence documentation of Home Health Aide testing. 4. Personnel file O, a Home Health 	N0600	<ol style="list-style-type: none"> 1. Personnel file G, a Home Health Aide, date of hire 1/19/12, failed to evidence documentation of Home Health Aide testing. Plan of Correction: Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 2. Personnel file J, a Home Health Aide, date of hire 1/23/12, failed to evidence documentation of Home Health Aide testing. Plan of Correction: Employee J was terminated on 3/15/12. Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home 	05/11/2012			

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NAME OF PROVIDER OR SUPPLIER FORTE HOME HEALTHCARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 808 A SOUTH HUNTINGTON STREET SYRACUSE, IN 46567			
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	<p>Aide, date of hire 1/23/12, failed to evidence documentation of Home Health Aide testing.</p> <p>5. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program ... 3) If the home health agency issuing the proof of the aide's achievement of successful completion of a competency evaluation program is not Forte HHC, Forte HHC shall ..." (next page missing).</p> <p>6. On 4/13/12 at 1:45 PM 1:45 PM, employee B indicated that employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were already on the Home Health Aide Registry so the agency figured that was all they needed to prove competency training.</p>		<p>Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 3. Personnel file L, a Home Health Aide, date of hire 1/23/12, failed to evidence documentation of Home Health Aide testing. Plan of Correction: Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 4. Personnel file O, a Home Health Aide, date of hire 1/23/12, failed to evidence</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/13/2012
NAME OF PROVIDER OR SUPPLIER FORTE HOME HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 808 A SOUTH HUNTINGTON STREET SYRACUSE, IN 46567		
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			documentation of Home Health Aide testing. Plan of Correction: Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 5. The agency's policy titled "Section 7-Home Health Aide Requirements," not dated, states under "7.1 Home Health Aide (HHA) Care. ... 1) Forte HHC shall be responsible for ensuring that, prior to client contact, the individuals who furnish home health aide services on its behalf met the requirements listed. The home health aide shall: have successfully completed a competency evaluation program ... 3) If the home health agency issuing the proof of the aide's achievement of successful completion of a competency evaluation program is not Forte HHC, Forte HHC shall ..." (next page missing).Plan of Correction: Forte Home Health Care has		

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			contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc 6. On 4/13/12 at 1:45 PM 1:45 PM, employee B indicated that employees G, J, L and O were already Home Health Aides upon dates of hire and they had completed their testing elsewhere. The employees were already on the Home Health Aide Registry so the agency figured that was all they needed to prove competency training. Plan of Correction: Forte Home Health Care has contracted with Amy Frazier RN, BSN, to provide Home Health Aide competency validation for all cited training deficiencies and future Home Health Aide training. See attachment. The deficiency has been corrected by contracting with an outside service for training. The outside service is required to supply documentation for each Home Health Aide that goes through training to prove the		

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			requirements have been met. That documentation will be stored in the employee's permanent personnel file. Responsible Person: A. Doctor RN, MA, MSN, FNP-Bc	