

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 04/04/2012
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NAME OF PROVIDER OR SUPPLIER BRIGHTSTAR OF VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 450 MORTHAND DR VALPARAISO, IN 46383
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N0000	<p>This visit was for a state home health agency initial licensure survey.</p> <p>Survey date: 4/2/12 - 4/4/12</p> <p>Facility #: 012679</p> <p>Medicaid #: NA</p> <p>Census: Skilled Patients 0 Home health aide only patients 4 Personal service only patients 5</p> <p>Total census: 9</p> <p>Surveyor: Ingrid Miller, MS, BSN, RN</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>April 12, 2012</p>	N0000		

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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N0456	<p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p> <p>Based on document review and interview, the administrator failed to ensure the quality assurance program was designed to objectively evaluate the quality and appropriateness of patient care, resolve identify problems, and improve patient care for 1 of 1 agency.</p> <p>Findings</p> <p>1. On 4/3/12 at 4:10 PM, Employee A, the administrator, and Employee F, the president and owner, indicated the quality assurance program was not in place at this time.</p> <p>2. The agency document titled "Job Description, Job Title: Administrator" with an approved date of 9/1/05 stated, "The administrator will ensure quality and appropriateness of services provided by agency personnel, as defined by Agency Policy as well as state and federal guidelines. This assurance will result</p>	N0456	<p>N456: The Administrator has reviewed and revised the Quality Assurance and Performance Improvement Plan to insure that the Quality Assurance system clearly identifies the Administrator position as the one clearly responsible for the ongoing Quality Assurance program for this office. Requirements to objectively and systematically monitor and report on the effectiveness and appropriateness of patient care, the timely resolution of identified problems, and the improvement of patient care are included within this policy. The Policy revision and training of office staff was completed on May 1, 2012. The Administrator will review monthly Quality Assurance metrics to insure compliance and to prevent the deficiency from recurring in the future. The Administrator is responsible for completion of the above action items. Date of Completion: May 1, 2012</p>	05/01/2012			

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	from the administrator's demonstrated understanding of the conditions of Participation, standards of care, involvement in Agency QI [quality improvement] programs."			

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N0462	<p>410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on personnel file and policy review and interview, the agency failed to ensure all employees had a physical exam within 180 days of first patient contact that identified the employee was free from communicable disease for 5 of 14 files reviewed with the potential to affect all the agency's patients.</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Personnel file E, date of hire 4/23/11 and first patient contact 9/17/11, failed to evidence a physical exam was completed within 180 days of the first patient contact. 2. Personnel file G, date of hire 8/23/11 and first patient contact 9/19/11, failed to evidence a physical exam was completed within 180 days of the first patient contact. 	N0462	<p>N462: Under the direction from the Administrator, the Director of Nursing audited all 18 employee files for inclusion of the employee's physicals within 180 days of direct patient contact. All 18 employees have a completed physical on file, however a total of 8 employees did not have the required "the employee will not spread infectious diseases or communicable diseases to patients" and thus they did not have a completed physical exam as all requirements were not met. The Director of Nursing has required the 8 employees to have new physicals including the requirement of being free of communicable diseases. In addition, the Employee Physical Form used by employees was updated to insure the need for including "free of communicable disease" is clearly communicated to the Physicians conducting the physical. New physicals will be completed and on file by May 15, 2012. <i>Under the direction of the</i></p>	05/15/2012			

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	<p>3. Personnel file H, date of hire 8/19/11 and first patient contact 10/7/11, failed to evidence a physical exam was completed within 180 days of the first patient contact.</p> <p>4. Personnel file I, date of hire 9/20/11 and first patient contact 12/20/11, failed to evidence a physical exam was completed within 180 days of the first patient contact.</p> <p>5. Personnel file L, date of hire 10/5/11 and first patient contact 2/15/12, failed to evidence a physical exam was completed within 180 days of the first patient contact.</p> <p>6. On 4/3/12 at 3:45 PM, Employee D, Registered Nurse, indicated the above employees lacked a complete physical examination.</p> <p>7. The agency policy titled "Health Screening" with an approved date of 11/23/11 stated, "All agency employees and contract personnel must have documentation of baseline health screening prior to providing care to patients. All agency employees and personnel working under contract who provide patient care will be free from communicable disease before providing direct patient care."</p>		<p><i>Administrator, the Director of Nursing monitors all employee files on a quarterly basis to insure that all required physicals are completed for new employees as well as insuring existing employees physicals are up to date. The Director of Nursing reports compliance/findings to the Administrator. The Director of Nursing is responsible for providing the quarterly monitoring and reporting to the Administrator. Completion Date: May 15, 2012</i></p>				

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N0464	<p>410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:</p> <p>(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.</p> <p>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.</p> <p>(3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii) completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest radiograph to exclude a diagnosis of tuberculosis.</p> <p>(4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on a tuberculosis evaluation may not:</p>						

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	<p>(A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on personnel file and policy review and interview, the agency failed to ensure Tuberculosis (TB) screenings with a two step Mantoux was completed upon hire if the employee did not have a negative tuberculin test within the previous twelve months or a chest x ray report was included for positive reactors for 1 of 14 files reviewed (E) with the potential to affect all the agency patients.</p> <p>Findings include</p> <p>1. Personnel file E, date of hire 4/23/11 and first patient contact 9/17/11, failed to evidence a two step tuberculosis screening was completed at hire or that the employee had documentation of a negative tuberculosis screening completed at hire or that the employee had documentation of a negative tuberculosis completed within the previous twelve months or a chest x ray report. Employee</p>	N0464	N464 Under the direction from the Administrator, the Director of Nursing audited all 18 employee files to insure compliance to the 2 step mantoux test. Consistent with the finding, one file was incomplete in that the Owner/Sales Manager did not have the required TB test and physical. The employee was instructed to have a new, complete physical including TB test before any further patient contact. The physical and TB will be completed and on file by May 15, 2012. Under the direction of the Administrator, the Director of Nursing monitors all emmployee files on a quarterly basis to insure that all required physicals are completed for both new and existing employees including the 2 step mantoux requirement. The Director of Nursing is responsible for providing the quarterly monitoring and reporting to the Administrator. Completion Date : May 15, 2012	05/15/2012			

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	<p>E is the sales manager for the agency and meets with the patients face to face at the start of care.</p> <p>2. On 4/3/12 at 3:45 PM, Employee D, Registered Nurse, indicated Employee E had not been evaluated for tuberculosis.</p> <p>3. The agency policy titled "Health Screening" with an approval date of 11/23/11 stated, "Tuberculosis testing: Any employee, staff member or contract personnel who provide care through direct patient contact must be evaluated for tuberculosis."</p>			

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N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on home visit observation, policy review and interview, the agency failed to ensure 2 of 2 home health aides (Employees G and H) observed followed infection control policies and procedures.</p> <p>Findings</p> <p>1. On 4/3/12 at 9 AM, Employee G, Home health aide (HHA), prior to caring for patient #4, was observed to wash hands. After completing the handwashing, the aide dried his/her hands with the patient's home towel.</p> <p>2. On 4/3/12 at 10 AM, Employee H, HHA, was observed to give a bed bath to patient #5. Employee H washed the peri area with the patient lying on the left side. As the aide washed the peri area, he/she swiped down the middle of the peri area to the anal area several times and rinsed the washcloth in the water. The water was not changed during this time.</p>	N0470	N470: The Director of Nursing completed a review of all appropriate procedures and in service training documents to insure that the proper information and process is in place to provide training for all Field Staff. On April 26, 2012 and April 30, 2012, the Director of Nursing held an in service for all Field Staff on the topic on the control of communicable disease including drying of hands, bathing, peri care, infection control plan, infectious disease, and CEU training. The Director of Nursing will conduct quarterly in service on Hand Hygiene and Infection Control for all new employees and existing employees as a refresher. Competency observations in the field are an ongoing process with requirements that adherence to this policy will be observed by the Director of Nursing for each Field Staff employee on an annual basis to prevent recurrence of this deficiency. The Administrator will confirm that all Field Staff have completed the in service through Director of Nurse reporting. Completion Date: May 1, 2012	05/01/2012			

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	<p>3. On 4/4/12 at 2 PM, the administrator and director of nursing indicated above aides did not follow infection control policy.</p> <p>4. The agency policy titled "Hand Hygiene Policy and Procedure' with a revised date of 9/15/10 stated, "Dry your hands with a disposal paper towel."</p> <p>5. The agency policy titled "Infection Control Plan Brightstar of Valparaiso" stated, "Plan: Limit unprotected exposure to pathogens, limit spread of infections associated with procedures."</p>			

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N0472	<p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>Based on document review and interview, the administrator failed to ensure the quality assurance program was designed to objectively evaluate the quality and appropriateness of patient care, resolve identified problems, and improve patient care for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings</p> <p>1. On 4/3/12 at 4:10 PM, Employee A, the administrator, and Employee F, the president and owner, indicated the quality assurance program was not in place at this time.</p> <p>2. The agency document titled "Job Description, Job Title: Administrator" with an approved date of 9/1/05 stated,</p>	N0472	<p>N 472: The Administrator has reviewed and revised the Quality Assurance and Performance Improvement Plan to insure a proper improvement process and culture is included within the process and office. A Plan, Do, Check, Act process has been implanted to insure improvement in our agency's performance across the spectrum of care. Objective metrics (key performance indicators) are imbedded within the process/policy requiring monthly monitoring and reporting. Under the direction of the Administrator, the Owner/President compiles and reports to the Administrator monthly Performance Improvement metrics and any reported deficiencies found. The results are posted on a quarterly basis for all employees to review. Quarterly Field Staff feedback sessions will be implemented.</p>	05/01/2012			

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	"The administrator will ensure quality and appropriateness of services provided by agency personnel, as defined by Agency Policy as well as state and federal guidelines. This assurance will result from the administrator's demonstrated understanding of the conditions of Participation, standards of care, involvement in Agency QI [quality improvement] programs."		This monthly oversight by the Administrator will insure the ongoing implementation of the Quality Assurance and Performance Improvement Plan. Completion Date: May 1, 2012	

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N0502	<p>410 IAC 17-12-3(b)(2)(C) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (C) Place a complaint with the department regarding treatment or care furnished by a home health agency.</p> <p>Based on document review, clinical record review, and interview, the agency failed to ensure the patient was aware of the Indiana Department of Health complaint hotline number for 9 of 9 records reviewed (Files 1 - 9).</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 12/19/11, failed to evidence patient rights included the Indiana State Department of Health (ISDH) complaint hotline number.</p> <p>2. Clinical record #2, SOC 11/11/11, failed to evidence patient rights included the ISDH complaint hotline number.</p> <p>3. Clinical record #3, SOC 10/3/11, failed to evidence patient rights included the ISDH complaint hotline number.</p>	N0502	<p>N502: The Administrator, Owner/President, and Director of Nursing reviewed the Patients Rights and Responsibilities Policy and appropriate forms. The form was found to be incomplete in that the ISDH hot line number was not included. The Director of Nursing revised the form to include the Hot Line number and an area for the patient to sign off on. The Administrator has confirmed that the Patients Rights and Responsibilities Form are correct and that this new form is included in all new patient admission packets. Completion Date: May 1, 2012</p>	05/01/2012			

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	<p>4. Clinical record #4, SOC 3/16/12, failed to evidence patient rights included the ISDH complaint hotline number.</p> <p>5. Clinical record #5, SOC 3/22/11, failed to evidence patient rights included the ISDH complaint hotline number.</p> <p>6. Clinical record #6, SOC 1/24/12, failed to evidence patient rights included the ISDH complaint hotline number.</p> <p>7. Clinical record #7, SOC 1/9/12, failed to evidence patient rights included the ISDH complaint hotline number.</p> <p>8. Clinical record #8, SOC 1/28/12, failed to evidence patient rights included the ISDH complaint hotline number.</p> <p>9. Clinical record #9, SOC 12/16/11, failed to evidence patient rights included the ISDH complaint hotline number.</p> <p>10. The agency policy titled "Patient's Rights and Responsibilities" failed to evidence the ISDH complaint phone number's availability.</p> <p>11. On 4/4/12 at 10:30 AM, Employee D, the director of nursing, indicated availability of the ISDH complaint number was not in the patient rights or agency policy and the above patients were</p>						

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	not aware of the availability of the state's complaint hotline number.			

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NAME OF PROVIDER OR SUPPLIER BRIGHTSTAR OF VALPARAISO				STREET ADDRESS, CITY, STATE, ZIP CODE 450 MORTHLAND DR VALPARAISO, IN 46383			
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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 home visit observation, record review, and document review, the agency failed to ensure the patient's rights, including respect and privacy, were honored for 1 of 2 home visit observations (Clinical record #4) with home health aide services (Employee G).</p> <p>Findings</p> <p>1. On 4/3/12 at 9 AM, Employee G, Home Health Aide, was observed to give a bed bath to Patient #4. During the bed bath, Employee G failed to cover Patient #4 with a bath blanket. The patient was undressed and exposed with no bed blanket or other covering for 15 minutes.</p> <p>2. Clinical record #4, start of care 3/16/12, evidenced a document titled "Brightstar service agreement" signed by the patient caregiver and Employee E, owner and sales manager, on 3/16/12. This document stated, "Client / Patient Rights and Responsibilities: I understand,</p>	N0512	<p>N512: The Administrator, Owner/President, and Director of Nursing reviewed the Patients Rights and Responsibilities Policy and appropriate forms. Root cause of this deficiency was found to be lack of proper execution by Field Staff. The Director of Nursing conducted in service training for all Field Staff personnel on April 26 and April 30, 2012 including proper understanding of the Patients Rights and Responsibilities policy including the right of the patient to be treated with dignity. The Administrator will confirm that all Field Staff personnel have attended the in service training. Ongoing compliance will be demonstrated through the system of Director of Nursing supervisor visits. In services and CEU training is an ongoing process throughout the calendar year. Completion date: May 1, 2012</p>	05/01/2012			

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	<p>have received and reviewed my client / patient rights and responsibilities as given to me by a Brightstar Representative."</p> <p>3. The agency document titled "Patient's rights and responsibilities" stated, "Be free of verbal, physical and psychological abuse and be treated with consideration, respect, and full recognition of your dignity and individuality, including privacy in treatment and care for your personal needs."</p>			

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N0533	<p>410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service.</p> <p>(b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure 3 of 4 records reviewed of patients (#1, 4, and 5) with nursing plans of care contained the name of the patient's physician.</p> <p>Findings</p> <p>1. Clinical record #1, start of care (SOC) 12/19/11, evidenced a document titled "Aide / Homemaker / Companion Plan of Care" signed by the Employee D, the director of nursing, on 12/19/11 which</p>	N0533	N533: The Administrator, Owner/President, and Director of Nursing reviewed the Client Clinical Record and Documentation Policy and Procedure. This policy was found to be deficient in that the requirement of a physicians name was not part of the Policy. The Director of Nursing has revised the subject Plan of Care document to meet the requirement for a physicians name, the duration and frequency of care, and medication list requirements are met. Current patients Plan of Care forms have	05/01/2012			

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	<p>failed to list the name of the primary physician.</p> <p>2. Clinical record #4, SOC 3/16/12, evidenced a document titled "Aide / Homemaker / Companion Plan of Care" signed by the Employee D on 3/16/12 which failed to list the name of the primary physician.</p> <p>3. Clinical record #5, SOC 3/22/12, evidenced a document titled "Aide / Homemaker / Companion Plan of Cares" signed by the Employee D on 3/22/12 which failed to list the name of the primary physician.</p> <p>4. The agency policy titled "Nursing Plan of Care" with an approved date of 12/2/11 stated, "A nursing plan of care must be developed by a Registered Nurse. This plan of care will be done in collaboration with family, physicians and other services received by the patient. The plan of care will be reviewed every 60 days or as needed based on client needs. The nursing plan of care must contain the following: A plan of care and appropriate patient identifying information, the name of the patient's physician, services to be provided, the frequency and duration of visits ... "</p> <p>5. On 4/4/12 at 10:15 AM, Employee D,</p>		<p>been audited by the Director of Nursing and updated with the physician's name. The Administrator has confirmed that the necessary system change has been implemented. Completion Date: May 1, 2012</p>				

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	the director of nursing, indicated the nursing plan of care lacked the primary physician's name.			

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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 personnel file and policivy review and interview, the agency failed to ensure home health aides furnishing home health aide services had successfully completed a competency evaluation program for 2 of 4 active home health aide personnel files reviewed (G and I) with the potential to affect all the agency's patients who received home health aide services.</p> <p>Findings</p> <p>1. Personnel file G, Home health aide (HHA) evidenced a document titled "Competency Assessment Skills Checklist for Home Health Aide." This document stated the following were discussed and /or quizzed but not observed or demonstrated: bed bath, shower /tub bath, nail care, skin care, oral care, shampoo and toileting /elimination including urinal and bedpan. This was signed by Employee M, Registered Nurse,</p>	N0596	<p>N596: The Administrator, Owner/President, and Director of Nursing reviewed the Competency Program and Verification Policy and Procedure. The determination was made that the policy was deficient due to a lack of understanding of the requirement of having all competencies observed and/or demonstrated (in addition to the testing, training, etc.). The Director of Nursing has revised the Policy to clarify the requirement of observation/demonstration of the competency in addition to the testing requirement. The Director of Nursing also audited all Field Staff personnel files to insure the necessary training is up to date and complete. The Administrator has confirmed the necessary changes to the Policy and Forms have been completed. An annual audit will be conducted of all employee files to insure that the competencies have been properly observed or demonstrated. A report of the audit will be</p>	05/01/2012			

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	<p>on 11/18/11.</p> <p>2. Personnel file I, HHA, evidenced a document titled "Competency Assessment Skills Checklist for Home Health Aide." This document stated the following were discussed and/or quizzed but were not observed or demonstrated: Shower, oral care, urinal, bedpan, and toileting on 12/19/11 and signed by Employee M, Registered Nurse.</p> <p>3. The agency policy titled "Home Health Aide Job Description" stated, "Qualifications ... Successful completion of a home health aide program."</p> <p>4. On 4/3/12 at 2 PM, Employee D, the director of nursing, indicated Employees G and I, both HHAs, had not been competency tested on the above tasks by observation or demonstration.</p>		<p>presented to the Administrator to insure ongoing compliance. Completion Date: May 1, 2012</p>	