

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157620	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/12/2012
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NAME OF PROVIDER OR SUPPLIER SERVANT'S HEART HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1714 DIVIDEND DRIVE LOGANSPORT, IN 46947
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G0000	<p>This visit was a federal home health complaint investigation survey.</p> <p>Complaint number: IN00105025 - Substantiated: Federal deficiencies related to the allegations are cited. Unrelated deficiencies are also cited.</p> <p>Survey dates: April 11 and 12, 2012</p> <p>Facility number: 011301</p> <p>Medicaid vendor number: 200852690</p> <p>Surveyors: Bridget Boston, RN, Public Health Nurse Surveyor Tonya Tucker, RN, Public Health Nurse Surveyor</p> <p>Patient Census:</p> <p>145 - home health only 111 - skilled</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 18, 2012</p>	G0000		

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

TITLE

(X6) DATE

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

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G0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review and interview, the agency failed to ensure the care provided followed the physician ordered plan of care in 2 of 5 clinical records reviewed with the potential to affect all the agency's patients. (# 1 and 3)</p> <p>Findings include:</p> <p>1. Clinical record # 1, start of care 9/16/11, evidenced a plan of care for the certification period 3/14/12 through 5/12/12 and orders which stated, "Fluid restriction of 1 liter per day of non sodium drinks, and one soft drink, ... HHA [home health aide] to visit patient 7 hours daily to assist patient in the morning getting out of bed, assist with bathing, toileting / incontinence care, morning and noon time meal preparation, assist with feeding, and stand by assist for safety / fall risk precautions X [for] 60 days."</p> <p>A. The clinical record evidenced a document dated 3/12/12 titled "Home Health Aide Assignment Sheet" that</p>	G0158	<p>Standard will be met as evidenced by: 1. On 4-18-12, a voice mail message was sent to all staff on our timekeeping system reminding them to follow the Plan of Care and Home Health Aide assignments for every patient. This voice mail also specifically addressed patients who have I & O ordered, to remind the staff to document I & O appropriately for every shift. 2. On 4-23-12, corrections were made in the chart for the patient who has fluid restrictions. The R.N. Case Manager reviewed the Plan of Care and the Home Health Aide Assignment form to ensure that fluid restrictions for the patient were clearly stated and the appropriate corrections were made. The aides providing care for this patient were contacted by the Case Manager and instructed on the fluid restriction and how to document appropriately. 3. A written memo will be given to all staff to re-educate them on the importance of following the Plan of Care and Home Health Aide assignment on 4-30-12. 4. A written inservice will be given to all aides regarding Fluid Balance, recording Intake/Output, and</p>	05/14/2012			

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	<p>stated, "Record Intake - only allowed 32 oz fluid daily."</p> <p>B. The record evidenced a document titled "Home Health Aide Notes - Weekly" which evidence the patient received 3.75 hours of aide services on 3/14/12 and failed to evidence a record of the fluids consumed by the patient.</p> <p>C. The record evidenced a document titled "Home Health Aide Notes - Weekly" which evidence the patient received aide services on March 15, 19, 21, 22, 25, 26, 27, 29, 30, and 31 and April 1, 2, 3, 4, and 5, 2012, and the documentation failed to evidence a record of the fluids that were consumed by the patient.</p> <p>D. On April 12, 2012, at 3 PM, the administrator indicated the clinical record does not clearly state how much of the fluid restriction the aides are to prepare and serve or administer to the patient and aide documentation does not clearly state the amount of the fluids the patient consumed during the individual aide visits.</p> <p>2. Clinical record 3, start of care 10/6/11, evidenced a plan of care for the certification period 2/5/12 through 4/4/12 with orders for home health aide services</p>		<p>special diets. This inservice will be completed no later than 5-14-12. 5. In order to prevent future problems with this issue, the Administrator and the R.N. Case Managers will conduct an audit of every active patient's chart, ensuring there is no missing documentation, and that the aides are following the Plan of Care and Home Health Aide Assignment appropriately. This audit will cover the current certification period for each patient, and will be completed no later than 5-14-12. 6. The Case managers will then do monthly audits to ensure that no further problems with this issue occur. The Case Managers will report their findings each month to the Administrator. If no further problems are found by the end of this 3 month period, quarterly chart audits will be performed by the Administrator and/or designee to review at least 10 % of every patient's chart and ensure that this Plan of Correction has been successful. This will be a part of our Performance Improvement program for at least the next 4 quarters.7. During our survey, it appeared that we had missed several visits due to a failure to produce the required documentation. On 4-20-12, the Advisory Board revised our Policy on Clinical Documentation (Policy C 680) to reflect the following change: "Documentation should be</p>				

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	<p>2 hours daily to assist with activities of daily living, oral care, dressing, medication reminders, and stated, "to get patient out of bed with use of Hoyer lift if necessary."</p> <p>A. The record failed to evidence the patient received services on February 26, 27, 28, and 29; March 1, 3, 7, 13, 16, 20, 22, and 29; and April 3, 2012.</p> <p>B. On April 12, 2012, at 2:47 PM, the administrator looked through the clinical record and indicated there was no documentation to evidence care was provided as ordered.</p>		<p><i>turned in every Monday by noon for the preceding week. All documentation will be reviewed by supervising staff (The Administrator, DON, ADON, Branch Managers, R.N. Case Managers, and/or Team Supervisors) on a weekly basis. <u>Any employee who has not turned in appropriate and complete documentation according to this policy will have a decrease in pay down to minimum wage for a period of at least one week.</u></i> This revised policy will be printed and given to all employees on Monday, April 30, 2012. Every employee will be required to read and sign the new policy on that date when they come to get their pay checks. 8. The Aides are required to turn in their documentation with their timesheets every Monday. When the documentation is turned in, the Administrator and/or designee(s) will compare the documentation to the aides' timekeeping record to ensure that all documentation has been submitted for every visit of that week. This will be a permanent change in our process effective immediately (4-18-12).9. All of the above steps were discussed and staff was educated regarding each issue during a staff meeting on 4-24-12.10. To summarize, all of the following steps will be completed and this standard will be met by 5-14-12: 4-18-12 –</p>		

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			<p>immediate re-education with staff via voice mail message</p> <p>4-23-12- Patient's record corrected and aides contacted to correct Intake and Output</p> <p>4-24-12 - Staff meeting to re-educate; written inservices given to staff for completion by 5-14-12 4-30-12 - New policy C680 signed by all staff 5-14-12</p> <p>- * Inservice completed regarding I & O and special diets</p> <p>* Audit completed on all patient charts for documentation; monthly audits will continue for 3 months * Performance Improvement Program to continue monitoring progress program for at least the next 4 quarters.</p>	

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G0176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse had coordinated care with the other providers of care to ensure optimal care for the patient in 1 (# 1) of 5 records reviewed creating the potential to affect all of the agency's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record # 1, start of care 9/16/11, evidenced the patient lived in a residential home and staff at the home also provided care to the patient. The record failed to evidence any coordination with the staff of the Bona Vista residential home. 2. On April 12, 2012, at 3 PM, employee A indicated there was no documentation of the agency coordinating with the Bona Vista residential home. 	G0176	<p>Standard will be met as evidenced by: 1. On 4-20-12, a form entitled "Informed Consent to Coordinate Care" was developed by the Administrator to be completed on admission with any patient who requires coordination of care. This form will verify any agencies or other providers that will be coordinating care with our services. The patient will sign this form to give permission to release and obtain information with the other provider(s). Information regarding the patient's health history and needs, as well as information regarding the current Plan of Care will be noted on this form. Any patient who has a legal guardian will be required to attach a copy of the Power of Attorney to the form. 2. An audit of the current census will be conducted by the Administrator and designees to identify any patients for whom this form needs to be utilized. All patients identified as requiring Coordination of Care will be contacted by their R.N. Case Mangers and the signed form will be in their charts no later than 4-30-2012. 3. Going forward, this form will be required at admission for all patients who have other providers and/or</p>	04/30/2012	

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			agencies involved in their care. 4. Quarterly chart audits will be done by the Administrator and/or designee to monitor for any further problems with Coordination of Care documentation. This will be a part of our Performance Improvement program for at least the next 4 quarters.	

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G0203	<p>484.36(a) HOME HEALTH AIDE SERVICES Home health aides are selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. They are closely supervised to ensure their competence in providing care. For home health services furnished (either directly or through arrangements with other organizations) after August 14, 1990, the HHA must use individuals who meet the personnel qualifications specified in §484.4 for "home health aide".</p> <p>Based on clinical record, personnel file, and agency policy review and staff interview, the agency failed to ensure it had used home health aides that had completed a competency evaluation that addressed all of the subject areas found at 42 CFR 484.36 (a)(1) and those specialized tasks required to care for their patient assignments in 8 (files D, E, F, G, H, I, J, and K) of 8 home health aide files reviewed with the potential to affect all the agency's patients receiving home health aide services.</p> <p>The findings include:</p> <p>1. 42 CFR 484.4 Personnel qualifications defines a home health aide as "a person who has successfully completed a State-established or other training program that meets the requirements of</p>	G0203	Standard will be met as evidenced by: 1. On 4-20-12, the Home Health Aide Skills Check Off form was revised to indicate more clearly each skill that must be demonstrated. The revision of this form will help to clarify exactly what skill is being demonstrated and the date when the aide demonstrated the skill correctly. 2. Each R.N. Case Manager has been assigned to a team of approximately 6 home health aides to perform a new and complete skill check off. Every aide will undergo a new skill check off, regardless of whether they were previously checked off or not. This check off will cover every required skill, and any additional skills that the individual aide might need to provide care for their clients. The new check offs will also include use of Hoyer lifts, understanding care of dysphagia patients, thickened	05/17/2012			

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	<p>484.36(a) and a competency evaluation program or State licensure program that meets the requirements of 484.36(b) or (e), or a competency evaluation program or State licensure program that meets the requirements of 484.36(b) or (e)."</p> <p>2. On 4/11/12 at 12:55 PM, the administrator indicated the caregiver of patient # 4 requested the aides feed the patient by means of a 60 cubic centimeter (cc) syringe since admission to home health services. She indicated the aides were uncomfortable but did feed the patient with the syringe. The administrator indicated the food was cooked by the caregiver, then the aides were to puree the food by placing in a blender or food processor and were also to thicken the patients liquids to pudding consistency. She indicated the aides were to transfer the patient by means of a Barton chair system into a sitting position, place the patient's head in a specific position, and then the caregiver requested the aides feed the patient by placing the pureed food or thickened liquid into the patient's mouth via the 60 cc syringe.</p> <p>3. On 4/11/12 at 4:30 PM, employee L, a registered nurse, indicated she only documents on the aide competency the skills demonstrated and indicated that if the skill was not available, the tasks are</p>		<p>liquids/pureed diets, patients who require I & O documentation, and fluid restrictions. The Case Managers will submit the check off documentation for each aide to the Administrator for signature as they are completed in order to verify that all of the aides have undergone a new and thorough skill check off. These check offs will be completed no later than 5-18-12. 3. Effective 4-18-12, before a new hire is allowed to work in the field as a qualified home health aide, the Administrator must be given a copy of the skill check off list for her signature as proof that the aide has had an appropriate skill check off and is cleared to work. The aide will not be allowed to job shadow or be scheduled to care for any patient without the Administrator's signature for confirmation. 4. An audit of at least 10% of every home health aide's personnel file will be done by the Administrator or designee on a quarterly basis for the Performance Improvement program for a minimum of the next 4 quarters to monitor for adherence to this protocol.</p>	

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	<p>discussed and not demonstrated.</p> <p>4. On April 12, 2012, at 2:38 PM, the administrator indicated the personnel files for employees F and H failed to evidence the employee was competency tested on use of a Hoyer lift and were rendering care to patients whom are transferred by a Hoyer.</p> <p>5. The undated policy titled "Competency Evaluation of Home Care Staff" states, "Purpose - To assure the personnel providing services to home care patients are trained, competent and able to respond to the needs of patients in safe and effective manner. ... Special Instructions. ... Home Health Aide Competency: ... Skills competency is evaluated by observing the aide with patient or "pseudo" patient (not a manikin). A home health aide will not be permitted to provide home health aide services until evidence of adequate training and / or competency has been determined by the designated professional in Servant's Heart Home Health Services. ... The home health aide must demonstrate evidence of: ... Successful completion of a competency evaluation program. The home health aide will have successfully completed the competency evaluation program if he / she demonstrates competency in a minimum of eleven of</p>						

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	the twelve areas required in federal guidelines. The required topics are: 1) communication skills, 2) observation, reporting, and documentation of patient status, 3) basic infection control procedures, 4) basic elements of body functioning and changes in body function that must be reported to a home health aides supervisor, 5) maintenance of clean, safe, and healthy environment, 6) adequate nutrition and fluid intake, 7) recognizing emergencies and knowledge of emergency procedures, 8) the physical, emotional, and developmental needs of the population served by Servant's Heart Home Health Services, including the need for respect of the patient, his or her privacy and property, 9) reading and recording temperature, pulse, and respiration, 10) appropriate and safe techniques in personal hygiene and grooming, including: a) bed bath, b) sponge, tub, or shower, c) shampoo in sink, tub, or bed, d) nail and skin care, e) oral hygiene, f) toileting and elimination, 11) safe transfer techniques and ambulation, and 12) normal range of motion and positioning. In addition to the above listed 12 required topics, any other task servant's Heart Home Health Services may choose to have the home health aide perform would be an appropriate topic. There must be evidence of home health aide orientation			

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	<p>to and competency in the delegated tasks not addressed here."</p> <p>6. During a home visit on April 11, 2012, at 1015 AM, the caregiver of patient number 4 indicated the patient was to be transferred via a Barton chair system. The system has been in the patient's home for approximately one year. The caregiver indicated one person was able to transfer the patient between surfaces with the system independently. The caregiver described the patient as totally dependent for all activities of daily living, unable to hold head upright while being fed and required the aide to position the patient's head appropriately for feeding. The caregiver prepared the patient's meals and requested the aides to puree the food and thicken all liquids to a pudding thick consistency and to feed the patient. The care giver indicated feeding was slow and there were 60 cc syringes in the home for feeding . It was easier to feed the patient if the food was placed in the mouth from the syringe, verses a spoon, as the patient had difficulty moving the food in the mouth to swallow. The caregiver indicated employee D rendered care at least once a week from August 2011 through February 2012.</p> <p>7. Clinical record # 2, start of care 3/7/12, evidenced a plan of care for the</p>			

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	<p>certification period 3/7/12 through 5/5/12 with orders for honey thick fluids and pureed diet.</p> <p>The record evidenced a document titled "Home Health Aide assignment Sheet" dated 3/7/12 and included the instructions for the aide - "pureed diet, thickened liquids, encourage fluids." The aides assignment failed to evidence the consistency of the patients thickened fluid and aspiration risk precautions for this patient.</p> <p>8. Clinical record 3, start of care 10/6/11, evidenced a plan of care for the certification period 2/5/12 through 4/4/12 with orders for home health aide services 2 hours daily to assist with activities of daily living, oral care, dressing, medication reminders, and stated, "to get patient out of bed with use of Hoyer lift if necessary."</p> <p>9. Clinical record # 4 evidenced start of care 3/17/11 and a plan of care dated 1/11/12 through 3/10/12 with orders for pudding thick liquids, Barton chair, aspiration precautions, pureed foods, suction machine to be used only by the caregiver, total assist with feeding, home health aides 5 days a week, 8 hours a day "to assist with ADL's and IADL's and personal hygiene." The plan of care</p>			

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	<p>stated, "The patient's [caregiver] and primary caregiver will understand importance of safety issues to prevent choking. ... Totally dependent for all care needs."</p> <p>Clinical record 4 evidenced a document titled "Home Health Aide assignment Sheet" dated 11/2/11 and 1/6/12 that stated, "Barton chair transfer system ... Feeding prepare breakfast, lunch, dinner, ... Feed * Hold head forward while feeding* ... Food must be pureed and liquids must be pudding thick*. Chokes easily feed slowly."</p> <p>10. Personnel file D, date of hire 5/23/11 and first patient contact 6/3/11, evidenced the document dated 6/3/11 titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating the skill was to be completed and evaluated on a client or pseudo - client. The document failed to</p>			

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	<p>evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bed bath, 6) nail care, 7) oral care, and 8) Hoyer transfer.</p> <p>A. The file evidenced the individual's application which failed to evidence experience working as an aide or caregiver for dependent adults, transferring patients by mechanical means and other physical assistance, and feeding patients with dysphagia.</p> <p>B. Clinical record 2 evidenced employee D was assigned and provided care on March 14, 17, and 18, 2012.</p> <p>C. Clinical record 3 evidenced employee D rendered care on March 15, 17, and 23, 2012.</p> <p>D. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 18 and 23 and February 1, 6, 8, 13, 15, 17, and 27, 2012, that identified employee D documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the</p>			

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	<p>patient between surfaces.</p> <p>11. Personnel file E, date of hire 3/30/11 and first patient contact 4/7/11, evidenced the document dated and titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contains a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) oral care of natural teeth, 6) hair care, 7) vital signs, and 8) mobility - ambulation assistance by means of a cane, walker, crutches.</p> <p>Clinical record 4 evidenced documents titled "Home Health Aide</p>			

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	<p>Notes - Weekly" dated January 12, 16, 23, and 25 and February 8, 17, 20, 22, 24, and 27, 2012 in which employee E documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces by means of the Barton chair.</p> <p>12. Personnel file F, date of hire 11/9/10 and first patient contact 11/19/10, evidenced the document dated 11/22/10 titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 cubic centimeter syringe, 4) transferring an individual by means of a</p>						

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	<p>BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, and 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced employee F provided care on March 22 and April 3, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 10, 17, 19, 24, 26, and 31; February 2, 6, 7, 9, 13, 14, 16, 20, 21, 23, and 28; and March 1, 2012 completed by employee F who documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>13. Personnel file G date of hire 8/21/07 evidenced the document dated 11/14/07, titled "Certified Home Health / Hospice Aide Check List" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating</p>			

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	<p>that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, and 5) positioning patient in bed.</p> <p>14. Personnel file H, date of hire 6/15/09 and first patient contact 6/8/10, evidenced a document titled "Certified Home Health / Hospice Aide Check List" dated as completed on 6/17/09 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening</p>			

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	<p>fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced employee H provided aide services on March 13 and 31, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 2 and 3, 2012, on which employee H documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>15. Personnel file I, date of hire 9/7/11 and first patient contact 9/12/11, evidenced the document dated 9/12/11 titled "Certified Home Health / Hospice Aide Check List" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be</p>			

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	<p>utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced employee I provided care on March 26, 27, 28, and 30, 2012. The document evidenced documentation which stated, "gave patient ensure."</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 11, 12, and 13, 2012 in which employee I documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>16. Personnel file J, date of hire 3/30/12 and first patient contact 3/30/12, evidenced a document titled "Certified</p>				

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	<p>Home Health / Hospice Aide Check List" dated 3/23/12 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... *</p> <p>Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) oral care, natural teeth, gum care and 6) nail care.</p> <p>A. Clinical record 2 evidenced employee J provided care on March 28, 30, and 31 and April 1, 2, 4, and 6, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 20, 27, and 30 and February 3, 9, 10, and 13,</p>			

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	<p>2012, in which employee J documented the care provided to the patient included prepared puree meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>17. Personnel file K, date of hire 9/7/11, evidenced the document titled "Certified Home Health / Hospice Aide Check List" dated as completed on 9/22/11 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced</p>			

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	<p>employee K was assigned and provided care to the patient on March 17 and 19, 2012. The documentation included the patient consumed fluids during the visits.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated February 3, 2012, in which employee K documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p>			

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G0211	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>An individual may furnish home health aide services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this paragraph.</p> <p>Based on personnel file and policy review and interview, the agency failed to ensure home health aides had completed a competency evaluation program that addressed all of the required subject areas and tasks necessary for the accepted patients and assignments for 8 (File D, E, F, G, H, I, J, and K) of 8 home health aide file reviewed with the potential to affect all the agency's patients receiving home health aide services.</p> <p>The findings include:</p> <p>1. On 4/11/12 at 12:55 PM, the administrator indicated the caregiver of patient # 4 requested the aides feed the patient by means of a 60 cubic centimeter (cc) syringe since admission to home health services. She indicated the aides were uncomfortable but did feed the patient with the syringe. The administrator indicated the food was cooked by the caregiver, then the aides were to puree the food by placing in a blender or food processor and were also to thicken the patients liquids to pudding</p>	G0211	<p>Standard will be met as evidenced by: 1. On 4-20-12, the Home Health Aide Skills Check Off form was revised to indicate more clearly each skill that must be demonstrated. The revision of this form will help to clarify exactly what skill is being demonstrated and the date when the aide demonstrated the skill correctly. 2. Each R.N. Case Manager has been assigned to a team of approximately 6 home health aides to perform a new and complete skill check off. Every aide will undergo a new skill check off, regardless of whether they were previously checked off or not. This check off will cover every required skill, and any additional skills that the individual aide might need to provide care for their clients. The new check offs will also include use of Hoyer lifts, understanding care of dysphagia patients, thickened liquids/pureed diets, patients who require I & O documentation, and fluid restrictions. The Case Managers will submit the check off documentation for each aide to the Administrator for signature as they are completed in order to verify that all of the aides have</p>	05/17/2012

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	<p>consistency. She indicated the aides were to transfer the patient by means of a Barton chair system into a sitting position, place the patient's head in a specific position, and then the caregiver requested the aides feed the patient by placing the pureed food or thickened liquid into the patient's mouth via the 60 cc syringe.</p> <p>2. On 4/11/12 at 4:30 PM, employee L, a registered nurse, indicated she only documents on the aide competency the skills demonstrated and indicated that if the skill was not available, the tasks are discussed and not demonstrated.</p> <p>3. On April 12, 2012, at 2:38 PM, the administrator indicated the personnel files for employees F and H failed to evidence the employee was competency tested on use of a Hoyer lift and were rendering care to patients whom are transferred by a Hoyer.</p> <p>4. The undated policy titled "Competency Evaluation of Home Care Staff" states, "Purpose - To assure the personnel providing services to home care patients are trained, competent and able to respond to the needs of patients in safe and effective manner. ... Special Instructions. ... Home Health Aide Competency: ... Skills competency is evaluated by observing the aide with patient or</p>		<p>undergone a new and thorough skill check off. These check offs will be completed no later than 5-18-12. 3. Effective 4-18-12, before a new hire is allowed to work in the field as a qualified home health aide, the Administrator must be given a copy of the skill check off list for her signature as proof that the aide has had an appropriate skill check off and is cleared to work. The aide will not be allowed to job shadow or be scheduled to care for any patient without the Administrator's signature for confirmation. 4. An audit of at least 10% of every home health aide's personnel file will be done by the Administrator or designee on a quarterly basis for the Performance Improvement program for a minimum of the next 4 quarters to monitor for adherence to this protocol.</p>		

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	"pseudo" patient (not a manikin). A home health aide will not be permitted to provide home health aide services until evidence of adequate training and / or competency has been determined by the designated professional in Servant's Heart Home Health Services. ... The home health aide must demonstrate evidence of: ... Successful completion of a competency evaluation program. The home health aide will have successfully completed the competency evaluation program if he / she demonstrates competency in a minimum of eleven of the twelve areas required in federal guidelines. The required topics are: 1) communication skills, 2) observation, reporting, and documentation of patient status, 3) basic infection control procedures, 4) basic elements of body functioning and changes in body function that must be reported to a home health aides supervisor, 5) maintenance of clean, safe, and healthy environment, 6) adequate nutrition and fluid intake, 7) recognizing emergencies and knowledge of emergency procedures, 8) the physical, emotional, and developmental needs of the population served by Servant's Heart Home Health Services, including the need for respect of the patient, his or her privacy and property, 9) reading and recording temperature, pulse, and respiration, 10) appropriate and safe			

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	<p>techniques in personal hygiene and grooming, including: a) bed bath, b) sponge, tub, or shower, c) shampoo in sink, tub, or bed, d) nail and skin care, e) oral hygiene, f) toileting and elimination, 11) safe transfer techniques and ambulation, and 12) normal range of motion and positioning. In addition to the above listed 12 required topics, any other task servant's Heart Home Health Services may choose to have the home health aide perform would be an appropriate topic. There must be evidence of home health aide orientation to and competency in the delegated tasks not addressed here."</p> <p>5. During a home visit on April 11, 2012, at 1015 AM, the caregiver of patient number 4 indicated the patient was to be transferred via a Barton chair system. The system has been in the patient's home for approximately one year. The caregiver indicated one person was able to transfer the patient between surfaces with the system independently. The caregiver described the patient as totally dependent for all activities of daily living, unable to hold head upright while being fed and required the aide to position the patient's head appropriately for feeding. The caregiver prepared the patient's meals and requested the aides to puree the food and thicken all liquids to a pudding thick</p>						

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	<p>consistency and to feed the patient. The care giver indicated feeding was slow and there were 60 cc syringes in the home for feeding . It was easier to feed the patient if the food was placed in the mouth from the syringe, verses a spoon, as the patient had difficulty moving the food in the mouth to swallow. The caregiver indicated employee D rendered care at least once a week from August 2011 through February 2012.</p> <p>6. Clinical record # 2, start of care 3/7/12, evidenced a plan of care for the certification period 3/7/12 through 5/5/12 with orders for honey thick fluids and pureed diet.</p> <p>The record evidenced a document titled "Home Health Aide assignment Sheet" dated 3/7/12 and included the instructions for the aide - "pureed diet, thickened liquids, encourage fluids." The aides assignment failed to evidence the consistency of the patients thickened fluid and aspiration risk precautions for this patient.</p> <p>7. Clinical record 3, start of care 10/6/11, evidenced a plan of care for the certification period 2/5/12 through 4/4/12 with orders for home health aide services 2 hours daily to assist with activities of daily living, oral care, dressing,</p>				

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	<p>medication reminders, and stated, "to get patient out of bed with use of Hoyer lift if necessary."</p> <p>8. Clinical record # 4 evidenced start of care 3/17/11 and a plan of care dated 1/11/12 through 3/10/12 with orders for pudding thick liquids, Barton chair, aspiration precautions, pureed foods, suction machine to be used only by the caregiver, total assist with feeding, home health aides 5 days a week, 8 hours a day "to assist with ADL's and IADL's and personal hygiene." The plan of care stated, "The patient's [caregiver] and primary caregiver will understand importance of safety issues to prevent choking. ... Totally dependent for all care needs."</p> <p>Clinical record 4 evidenced a document titled "Home Health Aide assignment Sheet" dated 11/2/11 and 1/6/12 that stated, "Barton chair transfer system ... Feeding prepare breakfast, lunch, dinner, ... Feed * Hold head forward while feeding* ... Food must be pureed and liquids must be pudding thick*. Chokes easily feed slowly."</p> <p>9. Personnel file D, date of hire 5/23/11 and first patient contact 6/3/11, evidenced the document dated 6/3/11 titled "Certified Home Health / Hospice Aide"</p>			

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	<p>that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bed bath, 6) nail care, 7) oral care, and 8) Hoyer transfer.</p> <p>A. The file evidenced the individual's application which failed to evidence experience working as an aide or caregiver for dependent adults, transferring patients by mechanical means and other physical assistance, and feeding patients with dysphagia.</p> <p>B. Clinical record 2 evidenced employee D was assigned and provided</p>			

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	<p>care on March 14, 17, and 18, 2012.</p> <p>C. Clinical record 3 evidenced employee D rendered care on March 15, 17, and 23, 2012.</p> <p>D. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 18 and 23 and February 1, 6, 8, 13, 15, 17, and 27, 2012, that identified employee D documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>10. Personnel file E, date of hire 3/30/11 and first patient contact 4/7/11, evidenced the document dated and titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contains a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to</p>						

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	<p>evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) oral care of natural teeth, 6) hair care, 7) vital signs, and 8) mobility - ambulation assistance by means of a cane, walker, crutches.</p> <p>Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 12, 16, 23, and 25 and February 8, 17, 20, 22, 24, and 27, 2012 in which employee E documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces by means of the Barton chair.</p> <p>11. Personnel file F, date of hire 11/9/10 and first patient contact 11/19/10, evidenced the document dated 11/22/10 titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any</p>			

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	<p>clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 cubic centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, and 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced employee F provided care on March 22 and April 3, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 10, 17, 19, 24, 26, and 31; February 2, 6, 7, 9, 13, 14, 16, 20, 21, 23, and 28; and March 1, 2012 completed by employee F who documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>12. Personnel file G date of hire 8/21/07</p>						

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	<p>evidenced the document dated 11/14/07, titled "Certified Home Health / Hospice Aide Check List" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... *</p> <p>Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, and 5) positioning patient in bed.</p> <p>13. Personnel file H, date of hire 6/15/09 and first patient contact 6/8/10, evidenced a document titled "Certified Home Health / Hospice Aide Check List" dated as completed on 6/17/09 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... *</p>			

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	<p>Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced employee H provided aide services on March 13 and 31, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 2 and 3, 2012, on which employee H documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the</p>						

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	<p>patient between surfaces.</p> <p>14. Personnel file I, date of hire 9/7/11 and first patient contact 9/12/11, evidenced the document dated 9/12/11 titled "Certified Home Health / Hospice Aide Check List" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced employee I provided care on March 26, 27, 28, and 30, 2012. The document evidenced documentation which stated,</p>						

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	<p>"gave patient ensure."</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 11, 12, and 13, 2012 in which employee I documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>15. Personnel file J, date of hire 3/30/12 and first patient contact 3/30/12, evidenced a document titled "Certified Home Health / Hospice Aide Check List" dated 3/23/12 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia</p>				

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	<p>with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) oral care, natural teeth, gum care and 6) nail care.</p> <p>A. Clinical record 2 evidenced employee J provided care on March 28, 30, and 31 and April 1, 2, 4, and 6, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 20, 27, and 30 and February 3, 9, 10, and 13, 2012, in which employee J documented the care provided to the patient included prepared puree meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>16. Personnel file K, date of hire 9/7/11, evidenced the document titled "Certified Home Health / Hospice Aide Check List" dated as completed on 9/22/11 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping</p>			

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	<p>there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced employee K was assigned and provided care to the patient on March 17 and 19, 2012. The documentation included the patient consumed fluids during the visits.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated February 3, 2012, in which employee K documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p>				

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G0213	<p>484.36(b)(2)(i) COMPETENCY EVALUATION & IN-SERVICE TRAI The competency evaluation must address each of the subjects listed in paragraphs (a) (1)(ii) through (xiii) of this section.</p> <p>Based on clinical record, personnel file, and agency policy review and staff interview, the agency failed to ensure home health aides had completed a competency evaluation that addressed all of the subject areas found at 42 CFR 484.36(a)(1)(ii) through (xiii) and specific patient care needs identified for which the aide was assigned and rendered care for 8 (File D, E, F, G, H, I, J, and K) of 8 home health aide file reviewed with the potential to affect all the agency's patients that received home health aide services.</p> <p>The findings include:</p> <p>1. On 4/11/12 at 12:55 PM, the administrator indicated the caregiver of patient # 4 requested the aides feed the patient by means of a 60 cubic centimeter (cc) syringe since admission to home health services. She indicated the aides were uncomfortable but did feed the patient with the syringe. The administrator indicated the food was cooked by the caregiver, then the aides were to puree the food by placing in a blender or food processor and were also to thicken the patients liquids to pudding</p>	G0213	<p>Standard will be met as evidenced by: 1. On 4-20-12, the Home Health Aide Skills Check Off form was revised to indicate more clearly each skill that must be demonstrated. The revision of this form will help to clarify exactly what skill is being demonstrated and the date when the aide demonstrated the skill correctly. 2. Each R.N. Case Manager has been assigned to a team of approximately 6 home health aides to perform a new and complete skill check off. Every aide will undergo a new skill check off, regardless of whether they were previously checked off or not. This check off will cover every required skill, and any additional skills that the individual aide might need to provide care for their clients. The new check offs will also include use of Hoyer lifts, understanding care of dysphagia patients, thickened liquids/pureed diets, patients who require I & O documentation, and fluid restrictions. The Case Managers will submit the check off documentation for each aide to the Administrator for signature as they are completed in order to verify that all of the aides have undergone a new and thorough skill check off. These check offs</p>	05/17/2012			

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	<p>consistency. She indicated the aides were to transfer the patient by means of a Barton chair system into a sitting position, place the patient's head in a specific position, and then the caregiver requested the aides feed the patient by placing the pureed food or thickened liquid into the patient's mouth via the 60 cc syringe.</p> <p>2. On 4/11/12 at 4:30 PM, employee L, a registered nurse, indicated she only documents on the aide competency the skills demonstrated and indicated that if the skill was not available, the tasks are discussed and not demonstrated.</p> <p>3. On April 12, 2012, at 2:38 PM, the administrator indicated the personnel files for employees F and H failed to evidence the employee was competency tested on use of a Hoyer lift and were rendering care to patients whom are transferred by a Hoyer.</p> <p>4. The undated policy titled "Competency Evaluation of Home Care Staff" states, "Purpose - To assure the personnel providing services to home care patients are trained, competent and able to respond to the needs of patients in safe and effective manner. ... Special Instructions. ... Home Health Aide Competency: ... Skills competency is evaluated by observing the aide with patient or</p>		<p>will be completed no later than 5-18-12. 3. Effective 4-18-12, before a new hire is allowed to work in the field as a qualified home health aide, the Administrator must be given a copy of the skill check off list for her signature as proof that the aide has had an appropriate skill check off and is cleared to work. The aide will not be allowed to job shadow or be scheduled to care for any patient without the Administrator's signature for confirmation. 4. An audit of at least 10% of every home health aide's personnel file will be done by the Administrator or designee on a quarterly basis for the Performance Improvement program for a minimum of the next 4 quarters to monitor for adherence to this protocol.</p>	

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	"pseudo" patient (not a manikin). A home health aide will not be permitted to provide home health aide services until evidence of adequate training and / or competency has been determined by the designated professional in Servant's Heart Home Health Services. ... The home health aide must demonstrate evidence of: ... Successful completion of a competency evaluation program. The home health aide will have successfully completed the competency evaluation program if he / she demonstrates competency in a minimum of eleven of the twelve areas required in federal guidelines. The required topics are: 1) communication skills, 2) observation, reporting, and documentation of patient status, 3) basic infection control procedures, 4) basic elements of body functioning and changes in body function that must be reported to a home health aides supervisor, 5) maintenance of clean, safe, and healthy environment, 6) adequate nutrition and fluid intake, 7) recognizing emergencies and knowledge of emergency procedures, 8) the physical, emotional, and developmental needs of the population served by Servant's Heart Home Health Services, including the need for respect of the patient, his or her privacy and property, 9) reading and recording temperature, pulse, and respiration, 10) appropriate and safe			

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	<p>techniques in personal hygiene and grooming, including: a) bed bath, b) sponge, tub, or shower, c) shampoo in sink, tub, or bed, d) nail and skin care, e) oral hygiene, f) toileting and elimination, 11) safe transfer techniques and ambulation, and 12) normal range of motion and positioning. In addition to the above listed 12 required topics, any other task servant's Heart Home Health Services may choose to have the home health aide perform would be an appropriate topic. There must be evidence of home health aide orientation to and competency in the delegated tasks not addressed here."</p> <p>5. During a home visit on April 11, 2012, at 1015 AM, the caregiver of patient number 4 indicated the patient was to be transferred via a Barton chair system. The system has been in the patient's home for approximately one year. The caregiver indicated one person was able to transfer the patient between surfaces with the system independently. The caregiver described the patient as totally dependent for all activities of daily living, unable to hold head upright while being fed and required the aide to position the patient's head appropriately for feeding. The caregiver prepared the patient's meals and requested the aides to puree the food and thicken all liquids to a pudding thick</p>						

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	<p>consistency and to feed the patient. The care giver indicated feeding was slow and there were 60 cc syringes in the home for feeding . It was easier to feed the patient if the food was placed in the mouth from the syringe, verses a spoon, as the patient had difficulty moving the food in the mouth to swallow. The caregiver indicated employee D rendered care at least once a week from August 2011 through February 2012.</p> <p>6. Clinical record # 2, start of care 3/7/12, evidenced a plan of care for the certification period 3/7/12 through 5/5/12 with orders for honey thick fluids and pureed diet.</p> <p>The record evidenced a document titled "Home Health Aide assignment Sheet" dated 3/7/12 and included the instructions for the aide - "pureed diet, thickened liquids, encourage fluids." The aides assignment failed to evidence the consistency of the patients thickened fluid and aspiration risk precautions for this patient.</p> <p>7. Clinical record 3, start of care 10/6/11, evidenced a plan of care for the certification period 2/5/12 through 4/4/12 with orders for home health aide services 2 hours daily to assist with activities of daily living, oral care, dressing,</p>				

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	<p>medication reminders, and stated, "to get patient out of bed with use of Hoyer lift if necessary."</p> <p>8. Clinical record # 4 evidenced start of care 3/17/11 and a plan of care dated 1/11/12 through 3/10/12 with orders for pudding thick liquids, Barton chair, aspiration precautions, pureed foods, suction machine to be used only by the caregiver, total assist with feeding, home health aides 5 days a week, 8 hours a day "to assist with ADL's and IADL's and personal hygiene." The plan of care stated, "The patient's [caregiver] and primary caregiver will understand importance of safety issues to prevent choking. ... Totally dependent for all care needs."</p> <p>Clinical record 4 evidenced a document titled "Home Health Aide assignment Sheet" dated 11/2/11 and 1/6/12 that stated, "Barton chair transfer system ... Feeding prepare breakfast, lunch, dinner, ... Feed * Hold head forward while feeding* ... Food must be pureed and liquids must be pudding thick*. Chokes easily feed slowly."</p> <p>9. Personnel file D, date of hire 5/23/11 and first patient contact 6/3/11, evidenced the document dated 6/3/11 titled "Certified Home Health / Hospice Aide"</p>			

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	<p>that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bed bath, 6) nail care, 7) oral care, and 8) Hoyer transfer.</p> <p>A. The file evidenced the individual's application which failed to evidence experience working as an aide or caregiver for dependent adults, transferring patients by mechanical means and other physical assistance, and feeding patients with dysphagia.</p> <p>B. Clinical record 2 evidenced employee D was assigned and provided</p>			

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	<p>care on March 14, 17, and 18, 2012.</p> <p>C. Clinical record 3 evidenced employee D rendered care on March 15, 17, and 23, 2012.</p> <p>D. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 18 and 23 and February 1, 6, 8, 13, 15, 17, and 27, 2012, that identified employee D documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>10. Personnel file E, date of hire 3/30/11 and first patient contact 4/7/11, evidenced the document dated and titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contains a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to</p>			

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	<p>evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) oral care of natural teeth, 6) hair care, 7) vital signs, and 8) mobility - ambulation assistance by means of a cane, walker, crutches.</p> <p>Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 12, 16, 23, and 25 and February 8, 17, 20, 22, 24, and 27, 2012 in which employee E documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces by means of the Barton chair.</p> <p>11. Personnel file F, date of hire 11/9/10 and first patient contact 11/19/10, evidenced the document dated 11/22/10 titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any</p>			

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	<p>clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 cubic centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, and 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced employee F provided care on March 22 and April 3, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 10, 17, 19, 24, 26, and 31; February 2, 6, 7, 9, 13, 14, 16, 20, 21, 23, and 28; and March 1, 2012 completed by employee F who documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>12. Personnel file G date of hire 8/21/07</p>						

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	<p>evidenced the document dated 11/14/07, titled "Certified Home Health / Hospice Aide Check List" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... *</p> <p>Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, and 5) positioning patient in bed.</p> <p>13. Personnel file H, date of hire 6/15/09 and first patient contact 6/8/10, evidenced a document titled "Certified Home Health / Hospice Aide Check List" dated as completed on 6/17/09 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... *</p>			

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	<p>Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced employee H provided aide services on March 13 and 31, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 2 and 3, 2012, on which employee H documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the</p>			

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	<p>patient between surfaces.</p> <p>14. Personnel file I, date of hire 9/7/11 and first patient contact 9/12/11, evidenced the document dated 9/12/11 titled "Certified Home Health / Hospice Aide Check List" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced employee I provided care on March 26, 27, 28, and 30, 2012. The document evidenced documentation which stated,</p>						

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	<p>"gave patient ensure."</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 11, 12, and 13, 2012 in which employee I documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>15. Personnel file J, date of hire 3/30/12 and first patient contact 3/30/12, evidenced a document titled "Certified Home Health / Hospice Aide Check List" dated 3/23/12 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia</p>						

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	<p>with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) oral care, natural teeth, gum care and 6) nail care.</p> <p>A. Clinical record 2 evidenced employee J provided care on March 28, 30, and 31 and April 1, 2, 4, and 6, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 20, 27, and 30 and February 3, 9, 10, and 13, 2012, in which employee J documented the care provided to the patient included prepared puree meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>16. Personnel file K, date of hire 9/7/11, evidenced the document titled "Certified Home Health / Hospice Aide Check List" dated as completed on 9/22/11 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping</p>			

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	<p>there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced employee K was assigned and provided care to the patient on March 17 and 19, 2012. The documentation included the patient consumed fluids during the visits.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated February 3, 2012, in which employee K documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p>				

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G0218	<p>484.36(b)(3)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section must be evaluated after observation of the aides performance of the tasks with a patient. The other subject areas in paragraph (a)(1) of this section may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient.</p> <p>Based on personnel file and policy review, and interview, the agency failed to ensure the home health aides competency evaluation program was completed to test the skills listed at paragraphs (a)(1) (ix) of this section and to meet any special patient needs for 8 (File D, E, F, G, H, I, J, and K) of 8 home health aide file reviewed with the potential to affect all the agency's patients that received home health aide services.</p> <p>The findings include:</p> <p>1. On 4/11/12 at 12:55 PM, the administrator indicated the caregiver of patient # 4 requested the aides feed the patient by means of a 60 cubic centimeter (cc) syringe since admission to home health services. She indicated the aides were uncomfortable but did feed the patient with the syringe. The administrator indicated the food was cooked by the caregiver, then the aides</p>	G0218	<p>Standard will be met as evidenced by: 1. On 4-20-12, the Home Health Aide Skills Check Off form was revised to indicate more clearly each skill that must be demonstrated. The revision of this form will help to clarify exactly what skill is being demonstrated and the date when the aide demonstrated the skill correctly. 2. Each R.N. Case Manager has been assigned to a team of approximately 6 home health aides to perform a new and complete skill check off. Every aide will undergo a new skill check off, regardless of whether they were previously checked off or not. This check off will cover every required skill, and any additional skills that the individual aide might need to provide care for their clients. The new check offs will also include use of Hoyer lifts, understanding care of dysphagia patients, thickened liquids/pureed diets, patients who require I & O documentation, and fluid restrictions. The Case Managers will submit the check</p>	05/17/2012			

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	<p>were to puree the food by placing in a blender or food processor and were also to thicken the patients liquids to pudding consistency. She indicated the aides were to transfer the patient by means of a Barton chair system into a sitting position, place the patient's head in a specific position, and then the caregiver requested the aides feed the patient by placing the pureed food or thickened liquid into the patient's mouth via the 60 cc syringe.</p> <p>2. On 4/11/12 at 4:30 PM, employee L, a registered nurse, indicated she only documents on the aide competency the skills demonstrated and indicated that if the skill was not available, the tasks are discussed and not demonstrated.</p> <p>3. On April 12, 2012, at 2:38 PM, the administrator indicated the personnel files for employees F and H failed to evidence the employee was competency tested on use of a Hoyer lift and were rendering care to patients whom are transferred by a Hoyer.</p> <p>4. The undated policy titled "Competency Evaluation of Home Care Staff" states, "Purpose - To assure the personnel providing services to home care patients are trained, competent and able to respond to the needs of patients in safe and effective manner. ... Special Instructions.</p>		<p>off documentation for each aide to the Administrator for signature as they are completed in order to verify that all of the aides have undergone a new and thorough skill check off. These check offs will be completed no later than 5-18-12. 3. Effective 4-18-12, before a new hire is allowed to work in the field as a qualified home health aide, the Administrator must be given a copy of the skill check off list for her signature as proof that the aide has had an appropriate skill check off and is cleared to work. The aide will not be allowed to job shadow or be scheduled to care for any patient without the Administrator's signature for confirmation. 4. An audit of at least 10% of every home health aide's personnel file will be done by the Administrator or designee on a quarterly basis for the Performance Improvement program for a minimum of the next 4 quarters to monitor for adherence to this protocol.</p>		

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	<p>... Home Health Aide Competency: ... Skills competency is evaluated by observing the aide with patient or "pseudo" patient (not a manikin). A home health aide will not be permitted to provide home health aide services until evidence of adequate training and / or competency has been determined by the designated professional in Servant's Heart Home Health Services. ... The home health aide must demonstrate evidence of: ... Successful completion of a competency evaluation program. The home health aide will have successfully completed the competency evaluation program if he / she demonstrates competency in a minimum of eleven of the twelve areas required in federal guidelines. The required topics are: 1) communication skills, 2) observation, reporting, and documentation of patient status, 3) basic infection control procedures, 4) basic elements of body functioning and changes in body function that must be reported to a home health aides supervisor, 5) maintenance of clean, safe, and healthy environment, 6) adequate nutrition and fluid intake, 7) recognizing emergencies and knowledge of emergency procedures, 8) the physical, emotional, and developmental needs of the population served by Servant's Heart Home Health Services, including the need for respect of the patient, his or her</p>			

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	<p>privacy and property, 9) reading and recording temperature, pulse, and respiration, 10) appropriate and safe techniques in personal hygiene and grooming, including: a) bed bath, b) sponge, tub, or shower, c) shampoo in sink, tub, or bed, d) nail and skin care, e) oral hygiene, f) toileting and elimination, 11) safe transfer techniques and ambulation, and 12) normal range of motion and positioning. In addition to the above listed 12 required topics, any other task servant's Heart Home Health Services may choose to have the home health aide perform would be an appropriate topic. There must be evidence of home health aide orientation to and competency in the delegated tasks not addressed here."</p> <p>5. During a home visit on April 11, 2012, at 1015 AM, the caregiver of patient number 4 indicated the patient was to be transferred via a Barton chair system. The system has been in the patient's home for approximately one year. The caregiver indicated one person was able to transfer the patient between surfaces with the system independently. The caregiver described the patient as totally dependent for all activities of daily living, unable to hold head upright while being fed and required the aide to position the patient's head appropriately for feeding. The</p>			

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	<p>caregiver prepared the patient's meals and requested the aides to puree the food and thicken all liquids to a pudding thick consistency and to feed the patient. The care giver indicated feeding was slow and there were 60 cc syringes in the home for feeding . It was easier to feed the patient if the food was placed in the mouth from the syringe, verses a spoon, as the patient had difficulty moving the food in the mouth to swallow. The caregiver indicated employee D rendered care at least once a week from August 2011 through February 2012.</p> <p>6. Clinical record # 2, start of care 3/7/12, evidenced a plan of care for the certification period 3/7/12 through 5/5/12 with orders for honey thick fluids and pureed diet.</p> <p>The record evidenced a document titled "Home Health Aide assignment Sheet" dated 3/7/12 and included the instructions for the aide - "pureed diet, thickened liquids, encourage fluids." The aides assignment failed to evidence the consistency of the patients thickened fluid and aspiration risk precautions for this patient.</p> <p>7. Clinical record 3, start of care 10/6/11, evidenced a plan of care for the certification period 2/5/12 through 4/4/12</p>			

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	<p>with orders for home health aide services 2 hours daily to assist with activities of daily living, oral care, dressing, medication reminders, and stated, "to get patient out of bed with use of Hoyer lift if necessary."</p> <p>8. Clinical record # 4 evidenced start of care 3/17/11 and a plan of care dated 1/11/12 through 3/10/12 with orders for pudding thick liquids, Barton chair, aspiration precautions, pureed foods, suction machine to be used only by the caregiver, total assist with feeding, home health aides 5 days a week, 8 hours a day "to assist with ADL's and IADL's and personal hygiene." The plan of care stated, "The patient's [caregiver] and primary caregiver will understand importance of safety issues to prevent choking. ... Totally dependent for all care needs."</p> <p>Clinical record 4 evidenced a document titled "Home Health Aide assignment Sheet" dated 11/2/11 and 1/6/12 that stated, "Barton chair transfer system ... Feeding prepare breakfast, lunch, dinner, ... Feed * Hold head forward while feeding* ... Food must be pureed and liquids must be pudding thick*. Chokes easily feed slowly."</p> <p>9. Personnel file D, date of hire 5/23/11</p>			

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	<p>and first patient contact 6/3/11, evidenced the document dated 6/3/11 titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bed bath, 6) nail care, 7) oral care, and 8) Hoyer transfer.</p> <p>A. The file evidenced the individual's application which failed to evidence experience working as an aide or caregiver for dependent adults, transferring patients by mechanical means and other physical assistance, and feeding patients with dysphagia.</p>			

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	<p>B. Clinical record 2 evidenced employee D was assigned and provided care on March 14, 17, and 18, 2012.</p> <p>C. Clinical record 3 evidenced employee D rendered care on March 15, 17, and 23, 2012.</p> <p>D. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 18 and 23 and February 1, 6, 8, 13, 15, 17, and 27, 2012, that identified employee D documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>10. Personnel file E, date of hire 3/30/11 and first patient contact 4/7/11, evidenced the document dated and titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contains a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group</p>						

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	<p>indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) oral care of natural teeth, 6) hair care, 7) vital signs, and 8) mobility - ambulation assistance by means of a cane, walker, crutches.</p> <p>Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 12, 16, 23, and 25 and February 8, 17, 20, 22, 24, and 27, 2012 in which employee E documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces by means of the Barton chair.</p> <p>11. Personnel file F, date of hire 11/9/10 and first patient contact 11/19/10, evidenced the document dated 11/22/10 titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo -</p>			

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	<p>client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 cubic centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, and 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced employee F provided care on March 22 and April 3, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 10, 17, 19, 24, 26, and 31; February 2, 6, 7, 9, 13, 14, 16, 20, 21, 23, and 28; and March 1, 2012 completed by employee F who documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the</p>			

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	<p>patient between surfaces.</p> <p>12. Personnel file G date of hire 8/21/07 evidenced the document dated 11/14/07, titled "Certified Home Health / Hospice Aide Check List" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, and 5) positioning patient in bed.</p> <p>13. Personnel file H, date of hire 6/15/09 and first patient contact 6/8/10, evidenced a document titled "Certified Home Health / Hospice Aide Check List" dated as</p>						

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	<p>completed on 6/17/09 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced employee H provided aide services on March 13 and 31, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 2 and 3, 2012, on which employee H documented</p>			

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	<p>the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>14. Personnel file I, date of hire 9/7/11 and first patient contact 9/12/11, evidenced the document dated 9/12/11 titled "Certified Home Health / Hospice Aide Check List" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced</p>			

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	<p>employee I provided care on March 26, 27, 28, and 30, 2012. The document evidenced documentation which stated, "gave patient ensure."</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 11, 12, and 13, 2012 in which employee I documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>15. Personnel file J, date of hire 3/30/12 and first patient contact 3/30/12, evidenced a document titled "Certified Home Health / Hospice Aide Check List" dated 3/23/12 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1)</p>			

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	<p>preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) oral care, natural teeth, gum care and 6) nail care.</p> <p>A. Clinical record 2 evidenced employee J provided care on March 28, 30, and 31 and April 1, 2, 4, and 6, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 20, 27, and 30 and February 3, 9, 10, and 13, 2012, in which employee J documented the care provided to the patient included prepared puree meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>16. Personnel file K, date of hire 9/7/11, evidenced the document titled "Certified Home Health / Hospice Aide Check List" dated as completed on 9/22/11 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing</p>						

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	<p>must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced employee K was assigned and provided care to the patient on March 17 and 19, 2012. The documentation included the patient consumed fluids during the visits.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated February 3, 2012, in which employee K documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p>			

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G0221	<p>484.36(b)(5) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA must maintain documentation which demonstrates that the requirements of this standard are met.</p> <p>Based on personnel file and policy review and interview, the agency failed to ensure documentation of the home health aide competency evaluation was met the requirements and specific needs of the patients accepted for service for 8 (File D, E, F, G, H, I, J, and K) of 8 home health aide file reviewed with the potential to affect all the agency's patients who received home health aide services.</p> <p>The findings include:</p> <p>1. On 4/11/12 at 12:55 PM, the administrator indicated the caregiver of patient # 4 requested the aides feed the patient by means of a 60 cubic centimeter (cc) syringe since admission to home health services. She indicated the aides were uncomfortable but did feed the patient with the syringe. The administrator indicated the food was cooked by the caregiver, then the aides were to puree the food by placing in a blender or food processor and were also to thicken the patients liquids to pudding consistency. She indicated the aides were to transfer the patient by means of a Barton chair system into a sitting position,</p>	G0221	<p>Standard will be met as evidenced by: 1. On 4-20-12, the Home Health Aide Skills Check Off form was revised to indicate more clearly each skill that must be demonstrated. The revision of this form will help to clarify exactly what skill is being demonstrated and the date when the aide demonstrated the skill correctly. 2. Each R.N. Case Manager has been assigned to a team of approximately 6 home health aides to perform a new and complete skill check off. Every aide will undergo a new skill check off, regardless of whether they were previously checked off or not. This check off will cover every required skill, and any additional skills that the individual aide might need to provide care for their clients. The new check offs will also include use of Hoyer lifts, understanding care of dysphagia patients, thickened liquids/pureed diets, patients who require I & O documentation, and fluid restrictions. The Case Managers will submit the check off documentation for each aide to the Administrator for signature as they are completed in order to verify that all of the aides have undergone a new and thorough skill check off. These check offs</p>	05/17/2012			

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	<p>place the patient's head in a specific position, and then the caregiver requested the aides feed the patient by placing the pureed food or thickened liquid into the patient's mouth via the 60 cc syringe.</p> <p>2. On 4/11/12 at 4:30 PM, employee L, a registered nurse, indicated she only documents on the aide competency the skills demonstrated and indicated that if the skill was not available, the tasks are discussed and not demonstrated.</p> <p>3. On April 12, 2012, at 2:38 PM, the administrator indicated the personnel files for employees F and H failed to evidence the employee was competency tested on use of a Hoyer lift and were rendering care to patients whom are transferred by a Hoyer.</p> <p>4. The undated policy titled "Competency Evaluation of Home Care Staff" states, "Purpose - To assure the personnel providing services to home care patients are trained, competent and able to respond to the needs of patients in safe and effective manner. ... Special Instructions. ... Home Health Aide Competency: ... Skills competency is evaluated by observing the aide with patient or "pseudo" patient (not a manikin). A home health aide will not be permitted to provide home health aide services until</p>		<p>will be completed no later than 5-18-12. 3. Effective 4-18-12, before a new hire is allowed to work in the field as a qualified home health aide, the Administrator must be given a copy of the skill check off list for her signature as proof that the aide has had an appropriate skill check off and is cleared to work. The aide will not be allowed to job shadow or be scheduled to care for any patient without the Administrator's signature for confirmation. 4. An audit of at least 10% of every home health aide's personnel file will be done by the Administrator or designee on a quarterly basis for the Performance Improvement program for a minimum of the next 4 quarters to monitor for adherence to this protocol.</p>		

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	evidence of adequate training and / or competency has been determined by the designated professional in Servant's Heart Home Health Services. ... The home health aide must demonstrate evidence of: ... Successful completion of a competency evaluation program. The home health aide will have successfully completed the competency evaluation program if he / she demonstrates competency in a minimum of eleven of the twelve areas required in federal guidelines. The required topics are: 1) communication skills, 2) observation, reporting, and documentation of patient status, 3) basic infection control procedures, 4) basic elements of body functioning and changes in body function that must be reported to a home health aides supervisor, 5) maintenance of clean, safe, and healthy environment, 6) adequate nutrition and fluid intake, 7) recognizing emergencies and knowledge of emergency procedures, 8) the physical, emotional, and developmental needs of the population served by Servant's Heart Home Health Services, including the need for respect of the patient, his or her privacy and property, 9) reading and recording temperature, pulse, and respiration, 10) appropriate and safe techniques in personal hygiene and grooming, including: a) bed bath, b) sponge, tub, or shower, c) shampoo in			

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	<p>sink, tub, or bed, d) nail and skin care, e) oral hygiene, f) toileting and elimination, 11) safe transfer techniques and ambulation, and 12) normal range of motion and positioning. In addition to the above listed 12 required topics, any other task servant's Heart Home Health Services may choose to have the home health aide perform would be an appropriate topic. There must be evidence of home health aide orientation to and competency in the delegated tasks not addressed here."</p> <p>5. During a home visit on April 11, 2012, at 1015 AM, the caregiver of patient number 4 indicated the patient was to be transferred via a Barton chair system. The system has been in the patient's home for approximately one year. The caregiver indicated one person was able to transfer the patient between surfaces with the system independently. The caregiver described the patient as totally dependent for all activities of daily living, unable to hold head upright while being fed and required the aide to position the patient's head appropriately for feeding. The caregiver prepared the patient's meals and requested the aides to puree the food and thicken all liquids to a pudding thick consistency and to feed the patient. The care giver indicated feeding was slow and there were 60 cc syringes in the home for</p>			

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	<p>feeding . It was easier to feed the patient if the food was placed in the mouth from the syringe, verses a spoon, as the patient had difficulty moving the food in the mouth to swallow. The caregiver indicated employee D rendered care at least once a week from August 2011 through February 2012.</p> <p>6. Clinical record # 2, start of care 3/7/12, evidenced a plan of care for the certification period 3/7/12 through 5/5/12 with orders for honey thick fluids and pureed diet.</p> <p>The record evidenced a document titled "Home Health Aide assignment Sheet" dated 3/7/12 and included the instructions for the aide - "pureed diet, thickened liquids, encourage fluids." The aides assignment failed to evidence the consistency of the patients thickened fluid and aspiration risk precautions for this patient.</p> <p>7. Clinical record 3, start of care 10/6/11, evidenced a plan of care for the certification period 2/5/12 through 4/4/12 with orders for home health aide services 2 hours daily to assist with activities of daily living, oral care, dressing, medication reminders, and stated, "to get patient out of bed with use of Hoyer lift if necessary."</p>			

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	<p>8. Clinical record # 4 evidenced start of care 3/17/11 and a plan of care dated 1/11/12 through 3/10/12 with orders for pudding thick liquids, Barton chair, aspiration precautions, pureed foods, suction machine to be used only by the caregiver, total assist with feeding, home health aides 5 days a week, 8 hours a day "to assist with ADL's and IADL's and personal hygiene." The plan of care stated, "The patient's [caregiver] and primary caregiver will understand importance of safety issues to prevent choking. ... Totally dependent for all care needs."</p> <p>Clinical record 4 evidenced a document titled "Home Health Aide assignment Sheet" dated 11/2/11 and 1/6/12 that stated, "Barton chair transfer system ... Feeding prepare breakfast, lunch, dinner, ... Feed * Hold head forward while feeding* ... Food must be pureed and liquids must be pudding thick*. Chokes easily feed slowly."</p> <p>9. Personnel file D, date of hire 5/23/11 and first patient contact 6/3/11, evidenced the document dated 6/3/11 titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must</p>			

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	<p>be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bed bath, 6) nail care, 7) oral care, and 8) Hoyer transfer.</p> <p>A. The file evidenced the individual's application which failed to evidence experience working as an aide or caregiver for dependent adults, transferring patients by mechanical means and other physical assistance, and feeding patients with dysphagia.</p> <p>B. Clinical record 2 evidenced employee D was assigned and provided care on March 14, 17, and 18, 2012.</p> <p>C. Clinical record 3 evidenced</p>			

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	<p>employee D rendered care on March 15, 17, and 23, 2012.</p> <p>D. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 18 and 23 and February 1, 6, 8, 13, 15, 17, and 27, 2012, that identified employee D documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>10. Personnel file E, date of hire 3/30/11 and first patient contact 4/7/11, evidenced the document dated and titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contains a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral</p>			

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	<p>consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) oral care of natural teeth, 6) hair care, 7) vital signs, and 8) mobility - ambulation assistance by means of a cane, walker, crutches.</p> <p>Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 12, 16, 23, and 25 and February 8, 17, 20, 22, 24, and 27, 2012 in which employee E documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces by means of the Barton chair.</p> <p>11. Personnel file F, date of hire 11/9/10 and first patient contact 11/19/10, evidenced the document dated 11/22/10 titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill</p>			

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	<p>grouping there is an asterisk preceding the group indicating the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 cubic centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, and 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced employee F provided care on March 22 and April 3, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 10, 17, 19, 24, 26, and 31; February 2, 6, 7, 9, 13, 14, 16, 20, 21, 23, and 28; and March 1, 2012 completed by employee F who documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>12. Personnel file G date of hire 8/21/07 evidenced the document dated 11/14/07, titled "Certified Home Health / Hospice Aide Check List" that stated, "Check</p>			

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	<p>skills being demonstrated. Initial and date when each skill is evaluated. ... *</p> <p>Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, and 5) positioning patient in bed.</p> <p>13. Personnel file H, date of hire 6/15/09 and first patient contact 6/8/10, evidenced a document titled "Certified Home Health / Hospice Aide Check List" dated as completed on 6/17/09 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... *</p> <p>Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must</p>						

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	<p>be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced employee H provided aide services on March 13 and 31, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 2 and 3, 2012, on which employee H documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>14. Personnel file I, date of hire 9/7/11</p>			

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	<p>and first patient contact 9/12/11, evidenced the document dated 9/12/11 titled "Certified Home Health / Hospice Aide Check List" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced employee I provided care on March 26, 27, 28, and 30, 2012. The document evidenced documentation which stated, "gave patient ensure."</p> <p>B. Clinical record 4 evidenced</p>			

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	<p>documents titled "Home Health Aide Notes - Weekly" dated January 11, 12, and 13, 2012 in which employee I documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>15. Personnel file J, date of hire 3/30/12 and first patient contact 3/30/12, evidenced a document titled "Certified Home Health / Hospice Aide Check List" dated 3/23/12 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair</p>			

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	<p>transport system, 5) oral care, natural teeth, gum care and 6) nail care.</p> <p>A. Clinical record 2 evidenced employee J provided care on March 28, 30, and 31 and April 1, 2, 4, and 6, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 20, 27, and 30 and February 3, 9, 10, and 13, 2012, in which employee J documented the care provided to the patient included prepared puree meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>16. Personnel file K, date of hire 9/7/11, evidenced the document titled "Certified Home Health / Hospice Aide Check List" dated as completed on 9/22/11 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or</p>			

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	<p>pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced employee K was assigned and provided care to the patient on March 17 and 19, 2012. The documentation included the patient consumed fluids during the visits.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated February 3, 2012, in which employee K documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p>			

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G0227	<p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Any home health aide services offered by an HHA must be provided by a qualified home health aide.</p> <p>Based on clinical record, personnel file, and agency policy review and staff interview, the agency failed to ensure home health aides that provided services on behalf of the agency were qualified and trained to meet the specific patient care needs identified in 8 (Files D, E, F, G, H, I, J and K) of 8 home health aide files reviewed with the potential to affect all the agency's patients that received home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 42 CFR 484.4 Personnel qualifications defines a home health aide as "a person who has successfully completed a State-established or other training program that meets the requirements of 484.36(a) and a competency evaluation program that meets the requirements of 484.36(b) or (e), or a competency evaluation program or State licensure program that meets the requirements of 484.36(b) or (e)." On 4/11/12 at 12:55 PM, the administrator indicated the caregiver of patient # 4 requested the aides feed the 	G0227	<p>Standard will be met as evidenced by: 1. On 4-20-12, the Home Health Aide Skills Check Off form was revised to indicate more clearly each skill that must be demonstrated. The revision of this form will help to clarify exactly what skill is being demonstrated and the date when the aide demonstrated the skill correctly.</p> <p>2. Each R.N. Case Manager has been assigned to a team of approximately 6 home health aides to perform a new and complete skill check off. Every aide will undergo a new skill check off, regardless of whether they were previously checked off or not. This check off will cover every required skill, and any additional skills that the individual aide might need to provide care for their clients. The new check offs will also include use of Hoyer lifts, understanding care of dysphagia patients, thickened liquids/pureed diets, patients who require I & O documentation, and fluid restrictions. The Case Managers will submit the check off documentation for each aide to the Administrator for signature as they are completed in order to verify that all of the aides have undergone a new and thorough skill check off. These check offs</p>	05/17/2012	

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	<p>patient by means of a 60 cubic centimeter (cc) syringe since admission to home health services. She indicated the aides were uncomfortable but did feed the patient with the syringe. The administrator indicated the food was cooked by the caregiver, then the aides were to puree the food by placing in a blender or food processor and were also to thicken the patients liquids to pudding consistency. She indicated the aides were to transfer the patient by means of a Barton chair system into a sitting position, place the patient's head in a specific position, and then the caregiver requested the aides feed the patient by placing the pureed food or thickened liquid into the patient's mouth via the 60 cc syringe.</p> <p>3. On 4/11/12 at 4:30 PM, employee L, a registered nurse, indicated she only documents on the aide competency the skills demonstrated and indicated that if the skill was not available, the tasks are discussed and not demonstrated.</p> <p>4. On April 12, 2012, at 2:38 PM, the administrator indicated the personnel files for employees F and H failed to evidence the employee was competency tested on use of a Hoyer lift and were rendering care to patients whom are transferred by a Hoyer.</p>		<p>will be completed no later than 5-18-12. 3. Effective 4-18-12, before a new hire is allowed to work in the field as a qualified home health aide, the Administrator must be given a copy of the skill check off list for her signature as proof that the aide has had an appropriate skill check off and is cleared to work. The aide will not be allowed to job shadow or be scheduled to care for any patient without the Administrator's signature for confirmation. 4. An audit of at least 10% of every home health aide's personnel file will be done by the Administrator or designee on a quarterly basis for the Performance Improvement program for a minimum of the next 4 quarters to monitor for adherence to this protocol.</p>	

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	<p>5. The undated policy titled "Competency Evaluation of Home Care Staff" states, "Purpose - To assure the personnel providing services to home care patients are trained, competent and able to respond to the needs of patients in safe and effective manner. ... Special Instructions. ... Home Health Aide Competency: ... Skills competency is evaluated by observing the aide with patient or "pseudo" patient (not a manikin). A home health aide will not be permitted to provide home health aide services until evidence of adequate training and / or competency has been determined by the designated professional in Servant's Heart Home Health Services. ... The home health aide must demonstrate evidence of: ... Successful completion of a competency evaluation program. The home health aide will have successfully completed the competency evaluation program if he / she demonstrates competency in a minimum of eleven of the twelve areas required in federal guidelines. The required topics are: 1) communication skills, 2) observation, reporting, and documentation of patient status, 3) basic infection control procedures, 4) basic elements of body functioning and changes in body function that must be reported to a home health aides supervisor, 5) maintenance of clean, safe, and healthy environment, 6)</p>			

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	<p>adequate nutrition and fluid intake, 7) recognizing emergencies and knowledge of emergency procedures, 8) the physical, emotional, and developmental needs of the population served by Servant's Heart Home Health Services, including the need for respect of the patient, his or her privacy and property, 9) reading and recording temperature, pulse, and respiration, 10) appropriate and safe techniques in personal hygiene and grooming, including: a) bed bath, b) sponge, tub, or shower, c) shampoo in sink, tub, or bed, d) nail and skin care, e) oral hygiene, f) toileting and elimination, 11) safe transfer techniques and ambulation, and 12) normal range of motion and positioning. In addition to the above listed 12 required topics, any other task servant's Heart Home Health Services may choose to have the home health aide perform would be an appropriate topic. There must be evidence of home health aide orientation to and competency in the delegated tasks not addressed here."</p> <p>6. During a home visit on April 11, 2012, at 1015 AM, the caregiver of patient number 4 indicated the patient was to be transferred via a Barton chair system. The system has been in the patient's home for approximately one year. The caregiver indicated one person was able to</p>			

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	<p>transfer the patient between surfaces with the system independently. The caregiver described the patient as totally dependent for all activities of daily living, unable to hold head upright while being fed and required the aide to position the patient's head appropriately for feeding. The caregiver prepared the patient's meals and requested the aides to puree the food and thicken all liquids to a pudding thick consistency and to feed the patient. The care giver indicated feeding was slow and there were 60 cc syringes in the home for feeding . It was easier to feed the patient if the food was placed in the mouth from the syringe, verses a spoon, as the patient had difficulty moving the food in the mouth to swallow. The caregiver indicated employee D rendered care at least once a week from August 2011 through February 2012.</p> <p>7. Clinical record # 2, start of care 3/7/12, evidenced a plan of care for the certification period 3/7/12 through 5/5/12 with orders for honey thick fluids and pureed diet.</p> <p>The record evidenced a document titled "Home Health Aide assignment Sheet" dated 3/7/12 and included the instructions for the aide - "pureed diet, thickened liquids, encourage fluids." The aides assignment failed to evidence the</p>			

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	<p>consistency of the patients thickened fluid and aspiration risk precautions for this patient.</p> <p>8. Clinical record 3, start of care 10/6/11, evidenced a plan of care for the certification period 2/5/12 through 4/4/12 with orders for home health aide services 2 hours daily to assist with activities of daily living, oral care, dressing, medication reminders, and stated, "to get patient out of bed with use of Hoyer lift if necessary."</p> <p>9. Clinical record # 4 evidenced start of care 3/17/11 and a plan of care dated 1/11/12 through 3/10/12 with orders for pudding thick liquids, Barton chair, aspiration precautions, pureed foods, suction machine to be used only by the caregiver, total assist with feeding, home health aides 5 days a week, 8 hours a day "to assist with ADL's and IADL's and personal hygiene." The plan of care stated, "The patient's [caregiver] and primary caregiver will understand importance of safety issues to prevent choking. ... Totally dependent for all care needs."</p> <p>Clinical record 4 evidenced a document titled "Home Health Aide assignment Sheet" dated 11/2/11 and 1/6/12 that stated, "Barton chair transfer</p>			

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	<p>system ... Feeding prepare breakfast, lunch, dinner, ... Feed * Hold head forward while feeding* ... Food must be pureed and liquids must be pudding thick*. Chokes easily feed slowly."</p> <p>10. Personnel file D, date of hire 5/23/11 and first patient contact 6/3/11, evidenced the document dated 6/3/11 titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bed bath, 6) nail care, 7) oral care, and 8) Hoyer transfer.</p>			

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	<p>A. The file evidenced the individual's application which failed to evidence experience working as an aide or caregiver for dependent adults, transferring patients by mechanical means and other physical assistance, and feeding patients with dysphagia.</p> <p>B. Clinical record 2 evidenced employee D was assigned and provided care on March 14, 17, and 18, 2012.</p> <p>C. Clinical record 3 evidenced employee D rendered care on March 15, 17, and 23, 2012.</p> <p>D. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 18 and 23 and February 1, 6, 8, 13, 15, 17, and 27, 2012, that identified employee D documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>11. Personnel file E, date of hire 3/30/11 and first patient contact 4/7/11, evidenced the document dated and titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client</p>			

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	<p>means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contains a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) oral care of natural teeth, 6) hair care, 7) vital signs, and 8) mobility - ambulation assistance by means of a cane, walker, crutches.</p> <p>Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 12, 16, 23, and 25 and February 8, 17, 20, 22, 24, and 27, 2012 in which employee E documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces by means of the Barton chair.</p> <p>12. Personnel file F, date of hire 11/9/10</p>			

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	<p>and first patient contact 11/19/10, evidenced the document dated 11/22/10 titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 cubic centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, and 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced employee F provided care on March 22 and April 3, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide</p>			

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	<p>Notes - Weekly" dated January 10, 17, 19, 24, 26, and 31; February 2, 6, 7, 9, 13, 14, 16, 20, 21, 23, and 28; and March 1, 2012 completed by employee F who documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>13. Personnel file G date of hire 8/21/07 evidenced the document dated 11/14/07, titled "Certified Home Health / Hospice Aide Check List" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... *</p> <p>Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair</p>			

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	<p>transport system, and 5) positioning patient in bed.</p> <p>14. Personnel file H, date of hire 6/15/09 and first patient contact 6/8/10, evidenced a document titled "Certified Home Health / Hospice Aide Check List" dated as completed on 6/17/09 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced</p>			

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	<p>employee H provided aide services on March 13 and 31, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 2 and 3, 2012, on which employee H documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>15. Personnel file I, date of hire 9/7/11 and first patient contact 9/12/11, evidenced the document dated 9/12/11 titled "Certified Home Health / Hospice Aide Check List" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3)</p>						

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	<p>feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced employee I provided care on March 26, 27, 28, and 30, 2012. The document evidenced documentation which stated, "gave patient ensure."</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 11, 12, and 13, 2012 in which employee I documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>16. Personnel file J, date of hire 3/30/12 and first patient contact 3/30/12, evidenced a document titled "Certified Home Health / Hospice Aide Check List" dated 3/23/12 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document</p>				

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	<p>contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) oral care, natural teeth, gum care and 6) nail care.</p> <p>A. Clinical record 2 evidenced employee J provided care on March 28, 30, and 31 and April 1, 2, 4, and 6, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 20, 27, and 30 and February 3, 9, 10, and 13, 2012, in which employee J documented the care provided to the patient included prepared puree meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>17. Personnel file K, date of hire 9/7/11, evidenced the document titled "Certified Home Health / Hospice Aide Check List" dated as completed on 9/22/11 that states,</p>			

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	<p>"Check skills being demonstrated. Initial and date when each skill is evaluated. ...</p> <p>* Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced employee K was assigned and provided care to the patient on March 17 and 19, 2012. The documentation included the patient consumed fluids during the visits.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated February 3, 2012, in which employee K documented the care provided included prepared pureed</p>			

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	meal and fed the patient, performed oral care, and transferred the patient between surfaces.			

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G0230	<p>484.36(d)(3) SUPERVISION</p> <p>If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 62 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure supervisory visits were completed at least every 30 days for 1 (patient 2) of 5 patients that received home health aide services only for more than 30 days.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record 2, start of care 3/7/12, evidenced a plan of care for the certification period 3/7/12 through 5/5/12 with orders for home health aide services daily for 60 days. The clinical record failed to evidence a supervisory visit was completed at least every 30 days. 2. On 4/12/12 at 3:12 PM, the administrator indicated the agency failed to evidence the aide was supervised at least every 30 days. 3. The undated policy titled "Home 	G0230	<p>Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. Group education by Administrator was done at staff meeting on 4-24-12 with all R.N.'s reviewing the standard regarding frequency of supervisory visits and the need to document any reason why supervisory visit was not done. 2. A three month calendar of all the Supervisory Visits that are due for every patient on the census will be submitted to the Administrator by the R.N. Case Managers no later than 5-2-12. The Supervisory Visits will be entered into the scheduling program for the entire 3 month period. The Administrator and/or designee will monitor our web based scheduling program on a weekly basis for the next 12 weeks (through 6-27-12) to verify that the SV's are on the RN's schedule for the appropriate dates. The 	05/02/2012	

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	Health Aide Supervision" stated, "When home health aide services are being furnished to a client, who does not require the skilled service ... a registered nurse ... must make a supervisory visit to the clients residence at least every 30 days."		<p>Supervisory Visit forms will be turned in to the Director and/or Assistant Director of Nurses on a weekly basis to verify that each visit is done. Additional education will be provided if evidence of non-compliance is noted after 12 weeks</p> <p>3. Chart reviews will then be done by the Administrator /designee on a quarterly basis of at least 10% of all patient charts to ensure that Supervisory Visits are being completed on time. This will be a part of our Performance Improvement Program for at least the next 4 quarters.</p>	

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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on clinical record review and interview, the agency failed to ensure the care provided followed the physician ordered plan of care in 2 of 5 clinical records reviewed with the potential to affect all the agency's patients. (# 1 and 3)</p> <p>Findings include:</p> <p>1. Clinical record # 1, start of care 9/16/11, evidenced a plan of care for the certification period 3/14/12 through 5/12/12 and orders which stated, "Fluid restriction of 1 liter per day of non sodium drinks, and one soft drink, ... HHA [home health aide] to visit patient 7 hours daily to assist patient in the morning getting out of bed, assist with bathing, toileting / incontinence care, morning and noon time meal preparation, assist with feeding, and stand by assist for safety / fall risk precautions X [for] 60 days."</p> <p>A. The clinical record evidenced a document dated 3/12/12 titled "Home Health Aide Assignment Sheet" that</p>	N0522	<p>Standard will be met as evidenced by: 1. On 4-18-12, a voice mail message was sent to all staff on our timekeeping system reminding them to follow the Plan of Care and Home Health Aide assignments for every patient. This voice mail also specifically addressed patients who have I & O ordered, to remind the staff to document I & O appropriately for every shift. 2. On 4-23-12, corrections were made in the chart for the patient who has fluid restrictions. The R.N. Case Manager reviewed the Plan of Care and the Home Health Aide Assignment form to ensure that fluid restrictions for the patient were clearly stated and the appropriate corrections were made. The aides providing care for this patient were contacted by the Case Manager and instructed on the fluid restriction and how to document appropriately. 3. A written memo will be given to all staff to re-educate them on the importance of following the Plan of Care and Home Health Aide assignment on 4-30-12. 4. A written inservice will be given to all aides regarding Fluid Balance, recording Intake/Output, and</p>	05/14/2012			

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	<p>stated, "Record Intake - only allowed 32 oz fluid daily."</p> <p>B. The record evidenced a document titled "Home Health Aide Notes - Weekly" which evidence the patient received 3.75 hours of aide services on 3/14/12 and failed to evidence a record of the fluids consumed by the patient.</p> <p>C. The record evidenced a document titled "Home Health Aide Notes - Weekly" which evidence the patient received aide services on March 15, 19, 21, 22, 25, 26, 27, 29, 30, and 31 and April 1, 2, 3, 4, and 5, 2012, and the documentation failed to evidence a record of the fluids that were consumed by the patient.</p> <p>D. On April 12, 2012, at 3 PM, the administrator indicated the clinical record does not clearly state how much of the fluid restriction the aides are to prepare and serve or administer to the patient and aide documentation does not clearly state the amount of the fluids the patient consumed during the individual aide visits.</p> <p>2. Clinical record 3, start of care 10/6/11, evidenced a plan of care for the certification period 2/5/12 through 4/4/12 with orders for home health aide services</p>		<p>special diets. This inservice will be completed no later than 5-14-12. 5. In order to prevent future problems with this issue, the Administrator and the R.N. Case Managers will conduct an audit of every active patient's chart, ensuring there is no missing documentation, and that the aides are following the Plan of Care and Home Health Aide Assignment appropriately. This audit will cover the current certification period for each patient, and will be completed no later than 5-14-12. 6. The Case managers will then do monthly audits to ensure that no further problems with this issue occur. The Case Managers will report their findings each month to the Administrator. If no further problems are found by the end of this 3 month period, quarterly chart audits will be performed by the Administrator and/or designee to review at least 10 % of every patient's chart and ensure that this Plan of Correction has been successful. This will be a part of our Performance Improvement program for at least the next 4 quarters.7. During our survey, it appeared that we had missed several visits due to a failure to produce the required documentation. On 4-20-12, the Advisory Board revised our Policy on Clinical Documentation (Policy C 680) to reflect the following change: "Documentation should be</p>				

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	<p>2 hours daily to assist with activities of daily living, oral care, dressing, medication reminders, and stated, "to get patient out of bed with use of Hoyer lift if necessary."</p> <p>A. The record failed to evidence the patient received services on February 26, 27, 28, and 29; March 1, 3, 7, 13, 16, 20, 22, and 29; and April 3, 2012.</p> <p>B. On April 12, 2012, at 2:47 PM, the administrator looked through the clinical record and indicated there was no documentation to evidence care was provided as ordered.</p>		<p><i>turned in every Monday by noon for the preceding week. All documentation will be reviewed by supervising staff (The Administrator, DON, ADON, Branch Managers, R.N. Case Managers, and/or Team Supervisors) on a weekly basis. <u>Any employee who has not turned in appropriate and complete documentation according to this policy will have a decrease in pay down to minimum wage for a period of at least one week.</u></i> This revised policy will be printed and given to all employees on Monday, April 30, 2012. Every employee will be required to read and sign the new policy on that date when they come to get their pay checks. 8. The Aides are required to turn in their documentation with their timesheets every Monday. When the documentation is turned in, the Administrator and/or designee(s) will compare the documentation to the aides' timekeeping record to ensure that all documentation has been submitted for every visit of that week. This will be a permanent change in our process effective immediately (4-18-12).9. All of the above steps were discussed and staff was educated regarding each issue during a staff meeting on 4-24-12.10. To summarize, all of the following steps will be completed and this standard will be met by 5-14-12: 4-18-12 –</p>		

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			<p>immediate re-education with staff via voice mail message 4-23-12- Patient's record corrected and aides contacted to correct Intake and Output 4-24-12 - Staff meeting to re-educate; written inservices given to staff for completion by 5-14-12 4-30-12 - New policy C680 signed by all staff 5-14-12 - * Inservice completed regarding I & O and special diets * Audit completed on all patient charts for documentation; monthly audits will continue for 3 months * Performance Improvement Program to continue monitoring progress program for at least the next 4 quarters.</p>	

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N0545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse had coordinated care with the other providers of care to ensure optimal care for the patient in 1 (# 1) of 5 records reviewed creating the potential to affect all of the agency's patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record # 1, start of care 9/16/11, evidenced the patient lived in a residential home and staff at the home also provided care to the patient. The record failed to evidence any coordination with the staff of the Bona Vista residential home. 2. On April 12, 2012, at 3 PM, employee A indicated there was no documentation of the agency coordinating with the Bona Vista residential home. 	N0545	<p>Standard will be met as evidenced by: 1. On 4-20-12, a form entitled "Informed Consent to Coordinate Care" was developed by the Administrator to be completed on admission with any patient who requires coordination of care. This form will verify any agencies or other providers that will be coordinating care with our services. The patient will sign this form to give permission to release and obtain information with the other provider(s). Information regarding the patient's health history and needs, as well as information regarding the current Plan of Care will be noted on this form. Any patient who has a legal guardian will be required to attach a copy of the Power of Attorney to the form. 2. An audit of the current census will be conducted by the Administrator and designees to identify any patients for whom this form needs to be utilized. All patients identified as requiring Coordination of Care will be contacted by their R.N. Case Mangers and the signed form will be in their charts no later than 4-30-2012. 3. Going forward, this form will be required at</p>	04/30/2012			

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			admission for all patients who have other providers and/or agencies involved in their care. 4. Quarterly chart audits will be done by the Administrator and/or designee to monitor for any further problems with Coordination of Care documentation. This will be a part of our Performance Improvement program for at least the next 4 quarters.	

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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 clinical record, personnel file, and agency policy review and staff interview, the agency failed to ensure home health aides had completed a competency evaluation that addressed all of the subject areas found at 410 IAC 17-14-1(h) and met the identified patient needs for 8 (File D, E, F, G, H, I, J and K) of 8 home health aide file reviewed.</p> <p>The findings include:</p> <p>1. On 4/11/12 at 12:55 PM, the administrator indicated the caregiver of patient # 4 requested the aides feed the patient by means of a 60 cubic centimeter (cc) syringe since admission to home health services. She indicated the aides were uncomfortable but did feed the patient with the syringe. The administrator indicated the food was cooked by the caregiver, then the aides were to puree the food by placing in a blender or food processor and were also</p>	N0596	<p>Standard will be met as evidenced by: 1. On 4-20-12, the Home Health Aide Skills Check Off form was revised to indicate more clearly each skill that must be demonstrated. The revision of this form will help to clarify exactly what skill is being demonstrated and the date when the aide demonstrated the skill correctly. 2. Each R.N. Case Manager has been assigned to a team of approximately 6 home health aides to perform a new and complete skill check off. Every aide will undergo a new skill check off, regardless of whether they were previously checked off or not. This check off will cover every required skill, and any additional skills that the individual aide might need to provide care for their clients. The new check offs will also include use of Hoyer lifts, understanding care of dysphagia patients, thickened liquids/pureed diets, patients who require I & O documentation, and fluid restrictions. The Case Managers will submit the check</p>	05/17/2012			

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	<p>to thicken the patients liquids to pudding consistency. She indicated the aides were to transfer the patient by means of a Barton chair system into a sitting position, place the patient's head in a specific position, and then the caregiver requested the aides feed the patient by placing the pureed food or thickened liquid into the patient's mouth via the 60 cc syringe.</p> <p>2. On 4/11/12 at 4:30 PM, employee L, a registered nurse, indicated she only documents on the aide competency the skills demonstrated and indicated that if the skill was not available, the tasks are discussed and not demonstrated.</p> <p>3. On April 12, 2012, at 2:38 PM, the administrator indicated the personnel files for employees F and H failed to evidence the employee was competency tested on use of a Hoyer lift and were rendering care to patients whom are transferred by a Hoyer.</p> <p>4. The undated policy titled "Competency Evaluation of Home Care Staff" states, "Purpose - To assure the personnel providing services to home care patients are trained, competent and able to respond to the needs of patients in safe and effective manner. ... Special Instructions. ... Home Health Aide Competency: ... Skills competency is evaluated by</p>		<p>off documentation for each aide to the Administrator for signature as they are completed in order to verify that all of the aides have undergone a new and thorough skill check off. These check offs will be completed no later than 5-18-12. 3. Effective 4-18-12, before a new hire is allowed to work in the field as a qualified home health aide, the Administrator must be given a copy of the skill check off list for her signature as proof that the aide has had an appropriate skill check off and is cleared to work. The aide will not be allowed to job shadow or be scheduled to care for any patient without the Administrator's signature for confirmation. 4. An audit of at least 10% of every home health aide's personnel file will be done by the Administrator or designee on a quarterly basis for the Performance Improvement program for a minimum of the next 4 quarters to monitor for adherence to this protocol.</p>				

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	<p>observing the aide with patient or "pseudo" patient (not a manikin). A home health aide will not be permitted to provide home health aide services until evidence of adequate training and / or competency has been determined by the designated professional in Servant's Heart Home Health Services. ... The home health aide must demonstrate evidence of: ... Successful completion of a competency evaluation program. The home health aide will have successfully completed the competency evaluation program if he / she demonstrates competency in a minimum of eleven of the twelve areas required in federal guidelines. The required topics are: 1) communication skills, 2) observation, reporting, and documentation of patient status, 3) basic infection control procedures, 4) basic elements of body functioning and changes in body function that must be reported to a home health aides supervisor, 5) maintenance of clean, safe, and healthy environment, 6) adequate nutrition and fluid intake, 7) recognizing emergencies and knowledge of emergency procedures, 8) the physical, emotional, and developmental needs of the population served by Servant's Heart Home Health Services, including the need for respect of the patient, his or her privacy and property, 9) reading and recording temperature, pulse, and</p>			

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	<p>respiration, 10) appropriate and safe techniques in personal hygiene and grooming, including: a) bed bath, b) sponge, tub, or shower, c) shampoo in sink, tub, or bed, d) nail and skin care, e) oral hygiene, f) toileting and elimination, 11) safe transfer techniques and ambulation, and 12) normal range of motion and positioning. In addition to the above listed 12 required topics, any other task servant's Heart Home Health Services may choose to have the home health aide perform would be an appropriate topic. There must be evidence of home health aide orientation to and competency in the delegated tasks not addressed here."</p> <p>5. During a home visit on April 11, 2012, at 1015 AM, the caregiver of patient number 4 indicated the patient was to be transferred via a Barton chair system. The system has been in the patient's home for approximately one year. The caregiver indicated one person was able to transfer the patient between surfaces with the system independently. The caregiver described the patient as totally dependent for all activities of daily living, unable to hold head upright while being fed and required the aide to position the patient's head appropriately for feeding. The caregiver prepared the patient's meals and requested the aides to puree the food and</p>			

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	<p>thicken all liquids to a pudding thick consistency and to feed the patient. The care giver indicated feeding was slow and there were 60 cc syringes in the home for feeding . It was easier to feed the patient if the food was placed in the mouth from the syringe, verses a spoon, as the patient had difficulty moving the food in the mouth to swallow. The caregiver indicated employee D rendered care at least once a week from August 2011 through February 2012.</p> <p>6. Clinical record # 2, start of care 3/7/12, evidenced a plan of care for the certification period 3/7/12 through 5/5/12 with orders for honey thick fluids and pureed diet.</p> <p>The record evidenced a document titled "Home Health Aide assignment Sheet" dated 3/7/12 and included the instructions for the aide - "pureed diet, thickened liquids, encourage fluids." The aides assignment failed to evidence the consistency of the patients thickened fluid and aspiration risk precautions for this patient.</p> <p>7. Clinical record 3, start of care 10/6/11, evidenced a plan of care for the certification period 2/5/12 through 4/4/12 with orders for home health aide services 2 hours daily to assist with activities of</p>				

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	<p>daily living, oral care, dressing, medication reminders, and stated, "to get patient out of bed with use of Hoyer lift if necessary."</p> <p>8. Clinical record # 4 evidenced start of care 3/17/11 and a plan of care dated 1/11/12 through 3/10/12 with orders for pudding thick liquids, Barton chair, aspiration precautions, pureed foods, suction machine to be used only by the caregiver, total assist with feeding, home health aides 5 days a week, 8 hours a day "to assist with ADL's and IADL's and personal hygiene." The plan of care stated, "The patient's [caregiver] and primary caregiver will understand importance of safety issues to prevent choking. ... Totally dependent for all care needs."</p> <p>Clinical record 4 evidenced a document titled "Home Health Aide assignment Sheet" dated 11/2/11 and 1/6/12 that stated, "Barton chair transfer system ... Feeding prepare breakfast, lunch, dinner, ... Feed * Hold head forward while feeding* ... Food must be pureed and liquids must be pudding thick*. Chokes easily feed slowly."</p> <p>9. Personnel file D, date of hire 5/23/11 and first patient contact 6/3/11, evidenced the document dated 6/3/11 titled</p>			

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	<p>"Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bed bath, 6) nail care, 7) oral care, and 8) Hoyer transfer.</p> <p>A. The file evidenced the individual's application which failed to evidence experience working as an aide or caregiver for dependent adults, transferring patients by mechanical means and other physical assistance, and feeding patients with dysphagia.</p> <p>B. Clinical record 2 evidenced</p>			

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	<p>employee D was assigned and provided care on March 14, 17, and 18, 2012.</p> <p>C. Clinical record 3 evidenced employee D rendered care on March 15, 17, and 23, 2012.</p> <p>D. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 18 and 23 and February 1, 6, 8, 13, 15, 17, and 27, 2012, that identified employee D documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>10. Personnel file E, date of hire 3/30/11 and first patient contact 4/7/11, evidenced the document dated and titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contains a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or</p>			

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	<p>pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) oral care of natural teeth, 6) hair care, 7) vital signs, and 8) mobility - ambulation assistance by means of a cane, walker, crutches.</p> <p>Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 12, 16, 23, and 25 and February 8, 17, 20, 22, 24, and 27, 2012 in which employee E documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces by means of the Barton chair.</p> <p>11. Personnel file F, date of hire 11/9/10 and first patient contact 11/19/10, evidenced the document dated 11/22/10 titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done</p>			

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	<p>with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 cubic centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, and 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced employee F provided care on March 22 and April 3, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 10, 17, 19, 24, 26, and 31; February 2, 6, 7, 9, 13, 14, 16, 20, 21, 23, and 28; and March 1, 2012 completed by employee F who documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p>			

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	<p>12. Personnel file G date of hire 8/21/07 evidenced the document dated 11/14/07, titled "Certified Home Health / Hospice Aide Check List" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, and 5) positioning patient in bed.</p> <p>13. Personnel file H, date of hire 6/15/09 and first patient contact 6/8/10, evidenced a document titled "Certified Home Health / Hospice Aide Check List" dated as completed on 6/17/09 that states, "Check skills being demonstrated. Initial and date</p>			

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	<p>when each skill is evaluated. ... *</p> <p>Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced employee H provided aide services on March 13 and 31, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 2 and 3, 2012, on which employee H documented the care provided included prepared pureed meal and fed the patient,</p>						

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	<p>performed oral care, and transferred the patient between surfaces.</p> <p>14. Personnel file I, date of hire 9/7/11 and first patient contact 9/12/11, evidenced the document dated 9/12/11 titled "Certified Home Health / Hospice Aide Check List" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced employee I provided care on March 26, 27, 28, and 30, 2012. The document</p>						

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	<p>evidenced documentation which stated, "gave patient ensure."</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 11, 12, and 13, 2012 in which employee I documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>15. Personnel file J, date of hire 3/30/12 and first patient contact 3/30/12, evidenced a document titled "Certified Home Health / Hospice Aide Check List" dated 3/23/12 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3)</p>				

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	<p>feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) oral care, natural teeth, gum care and 6) nail care.</p> <p>A. Clinical record 2 evidenced employee J provided care on March 28, 30, and 31 and April 1, 2, 4, and 6, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 20, 27, and 30 and February 3, 9, 10, and 13, 2012, in which employee J documented the care provided to the patient included prepared puree meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>16. Personnel file K, date of hire 9/7/11, evidenced the document titled "Certified Home Health / Hospice Aide Check List" dated as completed on 9/22/11 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be</p>			

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	<p>tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced employee K was assigned and provided care to the patient on March 17 and 19, 2012. The documentation included the patient consumed fluids during the visits.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated February 3, 2012, in which employee K documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p>			

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N0598	<p>410 IAC 17-14-1(l)(2) Scope of Services Rule 14 Sec. 1(l)(2) The home health agency shall maintain documentation which demonstrates that the requirements of this subsection and subsection (h) of this rule were met.</p> <p>Based on personnel file review and interview, the agency failed to ensure documentation of the home health aide competency evaluation was accurate and met the requirements for 8 (File D, E, F, G, H, I, J and K) of 8 home health aide file reviewed.</p> <p>The findings include:</p> <p>1. On 4/11/12 at 12:55 PM, the administrator indicated the caregiver of patient # 4 requested the aides feed the patient by means of a 60 cubic centimeter (cc) syringe since admission to home health services. She indicated the aides were uncomfortable but did feed the patient with the syringe. The administrator indicated the food was cooked by the caregiver, then the aides were to puree the food by placing in a blender or food processor and were also to thicken the patients liquids to pudding consistency. She indicated the aides were to transfer the patient by means of a Barton chair system into a sitting position, place the patient's head in a specific position, and then the caregiver requested</p>	N0598	<p>Standard will be met as evidenced by: 1. On 4-20-12, the Home Health Aide Skills Check Off form was revised to indicate more clearly each skill that must be demonstrated. The revision of this form will help to clarify exactly what skill is being demonstrated and the date when the aide demonstrated the skill correctly.</p> <p>2. Each R.N. Case Manager has been assigned to a team of approximately 6 home health aides to perform a new and complete skill check off. Every aide will undergo a new skill check off, regardless of whether they were previously checked off or not. This check off will cover every required skill, and any additional skills that the individual aide might need to provide care for their clients. The new check offs will also include use of Hoyer lifts, understanding care of dysphagia patients, thickened liquids/pureed diets, patients who require I & O documentation, and fluid restrictions. The Case Managers will submit the check off documentation for each aide to the Administrator for signature as they are completed in order to verify that all of the aides have undergone a new and thorough</p>	05/17/2012			

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	<p>the aides feed the patient by placing the pureed food or thickened liquid into the patient's mouth via the 60 cc syringe.</p> <p>2. On 4/11/12 at 4:30 PM, employee L, a registered nurse, indicated she only documents on the aide competency the skills demonstrated and indicated that if the skill was not available, the tasks are discussed and not demonstrated.</p> <p>3. On April 12, 2012, at 2:38 PM, the administrator indicated the personnel files for employees F and H failed to evidence the employee was competency tested on use of a Hoyer lift and were rendering care to patients whom are transferred by a Hoyer.</p> <p>4. The undated policy titled "Competency Evaluation of Home Care Staff" states, "Purpose - To assure the personnel providing services to home care patients are trained, competent and able to respond to the needs of patients in safe and effective manner. ... Special Instructions. ... Home Health Aide Competency: ... Skills competency is evaluated by observing the aide with patient or "pseudo" patient (not a manikin). A home health aide will not be permitted to provide home health aide services until evidence of adequate training and / or competency has been determined by the</p>		<p>skill check off. These check offs will be completed no later than 5-18-12. 3. Effective 4-18-12, before a new hire is allowed to work in the field as a qualified home health aide, the Administrator must be given a copy of the skill check off list for her signature as proof that the aide has had an appropriate skill check off and is cleared to work. The aide will not be allowed to job shadow or be scheduled to care for any patient without the Administrator's signature for confirmation. 4. An audit of at least 10% of every home health aide's personnel file will be done by the Administrator or designee on a quarterly basis for the Performance Improvement program for a minimum of the next 4 quarters to monitor for adherence to this protocol.</p>				

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	designated professional in Servant's Heart Home Health Services. ... The home health aide must demonstrate evidence of: ... Successful completion of a competency evaluation program. The home health aide will have successfully completed the competency evaluation program if he / she demonstrates competency in a minimum of eleven of the twelve areas required in federal guidelines. The required topics are: 1) communication skills, 2) observation, reporting, and documentation of patient status, 3) basic infection control procedures, 4) basic elements of body functioning and changes in body function that must be reported to a home health aides supervisor, 5) maintenance of clean, safe, and healthy environment, 6) adequate nutrition and fluid intake, 7) recognizing emergencies and knowledge of emergency procedures, 8) the physical, emotional, and developmental needs of the population served by Servant's Heart Home Health Services, including the need for respect of the patient, his or her privacy and property, 9) reading and recording temperature, pulse, and respiration, 10) appropriate and safe techniques in personal hygiene and grooming, including: a) bed bath, b) sponge, tub, or shower, c) shampoo in sink, tub, or bed, d) nail and skin care, e) oral hygiene, f) toileting and elimination,			

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	<p>11) safe transfer techniques and ambulation, and 12) normal range of motion and positioning. In addition to the above listed 12 required topics, any other task servant's Heart Home Health Services may choose to have the home health aide perform would be an appropriate topic. There must be evidence of home health aide orientation to and competency in the delegated tasks not addressed here."</p> <p>5. During a home visit on April 11, 2012, at 1015 AM, the caregiver of patient number 4 indicated the patient was to be transferred via a Barton chair system. The system has been in the patient's home for approximately one year. The caregiver indicated one person was able to transfer the patient between surfaces with the system independently. The caregiver described the patient as totally dependent for all activities of daily living, unable to hold head upright while being fed and required the aide to position the patient's head appropriately for feeding. The caregiver prepared the patient's meals and requested the aides to puree the food and thicken all liquids to a pudding thick consistency and to feed the patient. The care giver indicated feeding was slow and there were 60 cc syringes in the home for feeding . It was easier to feed the patient if the food was placed in the mouth from</p>						

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	<p>the syringe, verses a spoon, as the patient had difficulty moving the food in the mouth to swallow. The caregiver indicated employee D rendered care at least once a week from August 2011 through February 2012.</p> <p>6. Clinical record # 2, start of care 3/7/12, evidenced a plan of care for the certification period 3/7/12 through 5/5/12 with orders for honey thick fluids and pureed diet.</p> <p>The record evidenced a document titled "Home Health Aide assignment Sheet" dated 3/7/12 and included the instructions for the aide - "pureed diet, thickened liquids, encourage fluids." The aides assignment failed to evidence the consistency of the patients thickened fluid and aspiration risk precautions for this patient.</p> <p>7. Clinical record 3, start of care 10/6/11, evidenced a plan of care for the certification period 2/5/12 through 4/4/12 with orders for home health aide services 2 hours daily to assist with activities of daily living, oral care, dressing, medication reminders, and stated, "to get patient out of bed with use of Hoyer lift if necessary."</p> <p>8. Clinical record # 4 evidenced start of</p>			

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	<p>care 3/17/11 and a plan of care dated 1/11/12 through 3/10/12 with orders for pudding thick liquids, Barton chair, aspiration precautions, pureed foods, suction machine to be used only by the caregiver, total assist with feeding, home health aides 5 days a week, 8 hours a day "to assist with ADL's and IADL's and personal hygiene." The plan of care stated, "The patient's [caregiver] and primary caregiver will understand importance of safety issues to prevent choking. ... Totally dependent for all care needs."</p> <p>Clinical record 4 evidenced a document titled "Home Health Aide assignment Sheet" dated 11/2/11 and 1/6/12 that stated, "Barton chair transfer system ... Feeding prepare breakfast, lunch, dinner, ... Feed * Hold head forward while feeding* ... Food must be pureed and liquids must be pudding thick*. Chokes easily feed slowly."</p> <p>9. Personnel file D, date of hire 5/23/11 and first patient contact 6/3/11, evidenced the document dated 6/3/11 titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body</p>						

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	<p>not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bed bath, 6) nail care, 7) oral care, and 8) Hoyer transfer.</p> <p>A. The file evidenced the individual's application which failed to evidence experience working as an aide or caregiver for dependent adults, transferring patients by mechanical means and other physical assistance, and feeding patients with dysphagia.</p> <p>B. Clinical record 2 evidenced employee D was assigned and provided care on March 14, 17, and 18, 2012.</p> <p>C. Clinical record 3 evidenced employee D rendered care on March 15, 17, and 23, 2012.</p>			

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	<p>D. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 18 and 23 and February 1, 6, 8, 13, 15, 17, and 27, 2012, that identified employee D documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>10. Personnel file E, date of hire 3/30/11 and first patient contact 4/7/11, evidenced the document dated and titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contains a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use</p>			

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	<p>of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) oral care of natural teeth, 6) hair care, 7) vital signs, and 8) mobility - ambulation assistance by means of a cane, walker, crutches.</p> <p>Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 12, 16, 23, and 25 and February 8, 17, 20, 22, 24, and 27, 2012 in which employee E documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces by means of the Barton chair.</p> <p>11. Personnel file F, date of hire 11/9/10 and first patient contact 11/19/10, evidenced the document dated 11/22/10 titled "Certified Home Health / Hospice Aide" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating the skill was to be</p>			

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	<p>completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 cubic centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, and 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced employee F provided care on March 22 and April 3, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 10, 17, 19, 24, 26, and 31; February 2, 6, 7, 9, 13, 14, 16, 20, 21, 23, and 28; and March 1, 2012 completed by employee F who documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>12. Personnel file G date of hire 8/21/07 evidenced the document dated 11/14/07, titled "Certified Home Health / Hospice Aide Check List" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... *</p>						

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	<p>Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, and 5) positioning patient in bed.</p> <p>13. Personnel file H, date of hire 6/15/09 and first patient contact 6/8/10, evidenced a document titled "Certified Home Health / Hospice Aide Check List" dated as completed on 6/17/09 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... *</p> <p>Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be</p>			

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	<p>utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) bathing - shower, sponge bath, or shower, 6) Hoyer transfers.</p> <p>A. Clinical record 2 evidenced employee H provided aide services on March 13 and 31, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 2 and 3, 2012, on which employee H documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>14. Personnel file I, date of hire 9/7/11 and first patient contact 9/12/11, evidenced the document dated 9/12/11</p>			

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	<p>titled "Certified Home Health / Hospice Aide Check List" that stated, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... *</p> <p>Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced employee I provided care on March 26, 27, 28, and 30, 2012. The document evidenced documentation which stated, "gave patient ensure."</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 11, 12,</p>			

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NAME OF PROVIDER OR SUPPLIER SERVANT'S HEART HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1714 DIVIDEND DRIVE LOGANSPORT, IN 46947		
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	<p>and 13, 2012 in which employee I documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>15. Personnel file J, date of hire 3/30/12 and first patient contact 3/30/12, evidenced a document titled "Certified Home Health / Hospice Aide Check List" dated 3/23/12 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated competency in 1) preparing a pureed diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system, 5) oral care, natural teeth, gum care and 6) nail care.</p>				

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	<p>A. Clinical record 2 evidenced employee J provided care on March 28, 30, and 31 and April 1, 2, 4, and 6, 2012.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated January 20, 27, and 30 and February 3, 9, 10, and 13, 2012, in which employee J documented the care provided to the patient included prepared puree meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p> <p>16. Personnel file K, date of hire 9/7/11, evidenced the document titled "Certified Home Health / Hospice Aide Check List" dated as completed on 9/22/11 that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client. Pseudo - client means a live body not a manikin. Bathing must be done with the pseudo client not wearing any clothing or bathing must be utilizing a patient." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The document failed to evidence the individual demonstrated</p>						

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	<p>competency in 1) preparing a puree diet, 2) thickening fluids intended for oral consumption, 3) feeding of an individual with dysphagia with spoon or by the use of a 60 centimeter syringe, 4) transferring an individual by means of a BARTON chair transport system.</p> <p>A. Clinical record 2 evidenced employee K was assigned and provided care to the patient on March 17 and 19, 2012. The documentation included the patient consumed fluids during the visits.</p> <p>B. Clinical record 4 evidenced documents titled "Home Health Aide Notes - Weekly" dated February 3, 2012, in which employee K documented the care provided included prepared pureed meal and fed the patient, performed oral care, and transferred the patient between surfaces.</p>			

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N0606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure supervisory visits were completed at least every 30 days for 1 (patient 2) of 5 patients that received home health aide services only for more than 30 days.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record 2, start of care 3/7/12, evidenced a plan of care for the certification period 3/7/12 through 5/5/12 with orders for home health aide services daily for 60 days. The clinical record failed to evidence a supervisory visit was completed at least every 30 days. 2. On 4/12/12 at 3:12 PM, the administrator indicated the agency failed to evidence the aide was supervised at least every 30 days. 3. The undated policy titled "Home Health Aide Supervision" stated, "When home health aide services are being furnished to a client, who does not require 	N0606	<p>Standard will be met as evidenced by: 1. Group education by Administrator was done at staff meeting on 4-24-12 with all R.N.'s reviewing the standard regarding frequency of supervisory visits and the need to document any reason why supervisory visit was not done. 2. A three month calendar of all the Supervisory Visits that are due for every patient on the census will be submitted to the Administrator by the R.N. Case Managers no later than 5-2-12. The Supervisory Visits will be entered into the scheduling program for the entire 3 month period. The Administrator and/or designee will monitor our web based scheduling program on a weekly basis for the next 12 weeks (through 6-27-12) to verify that the SV's are on the RN's schedule for the appropriate dates. The Supervisory Visit forms will be turned in to the Director and/or Assistant Director of Nurses on a weekly basis to verify that each visit is done. Additional education will be provided if evidence of</p>	05/02/2012			

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	the skilled service ... a registered nurse ... must make a supervisory visit to the clients residence at least every 30 days."		non-compliance is noted after 12 weeks 3. Chart reviews will then be done by the Administrator /designee on a quarterly basis of at least 10% of all patient charts to ensure that Supervisory Visits are being completed on time. This will be a part of our Performance Improvement Program for at least the next 4 quarters.		