



Health Care Regulation & Quality Improvement
800 NE Oregon Street, Suite 465
Portland, Oregon 97232
971-673-0540
971-673-0556 (Fax)

IN-HOME CARE AGENCY SURVEY
Part I - Entrance Conference

Agency name & city:

Classification level:

Date/time of entrance conference: _____

Purpose of visit and survey process explained:

- Relicensure survey
- Complaint survey (#OR _____)

HCRQI surveyors/staff present at entrance:

Agency staff present at the entrance conference: _____

Introduction

Health Care Regulation & Quality Improvement (HCRQI) surveyor(s) are conducting an unannounced survey of your in-home care agency as required by the Oregon Administrative Rules (OARs), 333-536-0041 & 333-536-0043. This relicensure or complaint survey is to evaluate the agency's compliance with the applicable OARs. The surveyor(s) will conduct tasks which include, but are not limited to: interview of staff and review of agency records and documents.

Thank you in advance for your cooperation and assistance during this process!

The following are to be provided to the survey team

- Identification of a primary contact person or persons, designated by the agency administrator, with whom the interactive survey will be primarily conducted.

Contact person _____

- A place to work with a table and accommodations for privacy when needed.
- Provisions for copies of documents to be made as requested.

Photocopy contact person _____

- Description of branch office location(s), if applicable _____
- Verbal description of client record systems, including electronic documentation and policy for incorporating home records into office record. _____
- Number of clients on service _____
- Number of caregivers and nurses providing services _____, lic/cert of Nurse _____
- List of all clients who received any services during the past twelve months, including all clients served from branch office(s). Include the start of service date and identify all services provided.

- List of all caregivers and nurses who provided any services for the past twelve months, including all those providing services to branch office(s) clients. Include the hire date and title/position held.
- Current employee file for the agency registered nurse and the qualified individual providing medication training and return demonstrations (if different from RN).
- Current client admission packet including a blank Disclosure Statement form and service agreement/contact.
- All the internal investigation documentation for complaints, grievances, accidents, incidents, medication or treatment errors and allegations of abuse or neglect for the past twelve months. Include follow-up and resolution documentation.
- Quality improvement program plan and all activity for the past three years.
- Current, written, agency-specific policies and procedures.
- Orientation, training curriculums, and competency evaluation materials should be ready and available.
- Agency's business license for city, county or local jurisdiction, for residential businesses, proof of approved business zoning.
- Other documents and materials, as requested.

Entrance conference notes

**IN-HOME CARE AGENCY SURVEY
Part II - Survey Process**

The review of records and documents will be conducted with agency staff in an interactive way in order to gather information about the agency's operations. The surveyor(s) will be asking for answers to the following questions during this interactive review. This information will be used to determine the agency's compliance with the OARs applicable to the agency's classification level.

Projected timeline for survey task completion

Times may vary based on things such as:

- the length of time it takes for the agency to provide the requested lists and materials;
- survey of a higher classification level;
- number of clients served by agency; completeness and accuracy of personnel records, including criminal records checks and training;
- completeness and accuracy of client records, including client-specific service plans and documentation of services provided.

½ hr	Entrance conference
3½ hrs	Interactive review of selected sample of client records
2 hrs	Interactive review of selected sample of personnel records
½ hr	Interactive review of complaint and incident investigations
½ hr	Interactive review of quality improvement activity
½ hr	Surveyor(s) compile preliminary findings and obtain relevant policies and procedures
<u>½ hr</u>	<u>Exit conference</u>
8 hrs	Total

Survey interview questions for all classifications

- Describe the employee screening process, how do you decide to hire a caregiver, and how is that documented?
- Describe the caregiver training process, how do you decide a caregiver is competent to provide services, and how is that documented?
- Describe the client screening and disclosure process, how do you ensure each client receives all information required to be disclosed, including information about client's rights?
- Describe how the client service plan is developed, how changes to the service plan are identified or initiated, and how is that documented?
- Describe how service plan information, and changes to the service plan, are communicated to caregivers and how is that documented?
- Describe medication reminding, how you decide whether the agency will provide that service to a client, and how is that decision documented?
- Describe how caregivers document the provision of services they provide.
- Describe how and when caregivers are supervised and how is that documented?
- Describe how services provided from branch office(s) are supervised by the parent agency.
- Describe how the services provided by your agency are coordinated with other health providers such as home health, hospice, and facilities, and how is that coordination documented?
- Describe how the agency responds to complaints, grievances, allegations of abuse or neglect, accidents, incidents, and how is that documented?
- Describe how, and how often, through the quality improvement program the agency evaluates and monitors the quality, safety and appropriateness of the applicable personal care, medication, and nursing services it provides?

Additional survey interview questions for Basic and Intermediate classifications

- Describe how you decide that the agency will provide medication assistance services to a client, how is that decision documented, and how are those services incorporated into the service plan?
- Describe how clients are evaluated for the provision of medication administration services, how that decision is documented, and how are those services incorporated into the client service plan?
- Describe the caregiver training process for medication services, how do you decide a caregiver is competent to provide services, and how is that documented?
- Describe what physician orders are required for medication services, who is responsible for obtaining those, what is the process, and how are those documented?
- Describe how caregivers document the provision of the medication services they provide.
- Describe what type of medications require additional measures to prevent theft or loss, what systems are in place to address that, and how is that documented?
- Describe the role of the Registered Nurse (RN) in relation to the medication services provided by your agency.
- Describe how the agency responds to medication errors and how is that documented?
- Describe your systems which ensure that each client receives the right medication, in the right amount, by the right route, and at the right time.

Additional survey interview questions for Comprehensive classification

- Describe the role of the RN in relation to nursing services provided by your agency, including what tasks the RN is responsible for?
- Describe how clients are evaluated for the provision of nursing services and how are those services incorporated into the client service plan?
- Describe the process for RN delegation of special tasks of nursing care and how is that documented?
- Describe what physician orders are required for nursing services, who is responsible for obtaining those, what is the process, and how are those documented?

IN-HOME CARE AGENCY SURVEY
Part III - Exit Conference

Date/time of exit conference: _____

HCRQI surveyors/staff present at the exit conference: _____

Agency staff present at the exit conference: _____

Summary of preliminary findings

The following are preliminary findings that may result in a written statement of deficiencies. If a written statement of deficiencies is issued, it may include additional findings.

1. _____

2. _____

3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

Next steps and survey report

Please do not send additional records or documents to the surveyor(s) after the survey unless expressly requested in today's survey.

If a written Statement of Deficiencies (SOD) report is issued, you must submit a written plan of correction (POC) that addresses each deficiency cited. Instructions will be included with the report.

For more information related to informal and formal enforcement requirements, please refer to OARs Chapter 333, Division 536, Sections 0117 and 0120.

Thank you again for your cooperation and assistance during this process!

IN-HOME CARE SURVEY
PERSONNEL Record Review

Agency _____ Date _____ Surveyor _____ Employee # _____

Employee's name	
Employee's title	
Circle: CNA CMA RN LPN - Is OSBN lic/cert. current? 333-536-0050(9)	
Date of hire	
Date started providing care/services to clients	
Clients in sample to whom services provided (initials or identifier)	
Caregiver training: Date completed and includes at least: 333-536-0070(4)(a-b) (A) Caregivers' duties and responsibilities; (B) Recognizing and responding to medical emergencies; (C) Dealing with adverse behaviors; (D) Nutrition and hydration, including special diets, meal preparation and service; (E) Appropriate and safe techniques in personal care tasks; (F) Methods and techniques to prevent skin breakdown, contractures, and falls; (G) Hand washing and infection control; (H) Body mechanics; (I) Maintenance of a clean and safe environment; and (J) Fire safety and non-medical emergency procedures. (K-L) If agency provides Medication (see rule) (b) The content of the training, the date(s) and length, and name(s) and signature(s) of the instructors shall be clearly documented.	
Competency evaluation: Methods and date completed 333-536-0070(4)	
Medication training: Date completed and includes at least: 333-536-0075(10)(a) & (c) (A) Medication abbreviations; (B) Reading medication orders and directions; (C) Reading medication labels and packages; (D) Setting up medication labels and packages; (E) Administering non-injectable medications: (i) Pill forms, including identification of pills that cannot be crushed; (ii) Non-injectable liquid forms, including those administered by syringe or dropper and eye and ear drops; (iii) Suppository forms; and (iv) Topical forms. (F) Identifying and reporting adverse medication reactions, interactions, contraindications and side effects; (G) Infection control related to medication administration; and (H) Techniques and methods to ensure safe and accurate medication administration. (c)The content of the medication training, the dates and length of training, the identity of the qualified individual or qualified entity, evidence of successful return demonstrations, and the instructor's statement that the caregiver has been evaluated to be competent to provide the medication services described in this rule shall be clearly documented	

Medication competency evaluation: Methods, including return demonstration, and date completed 333-536-0075(10)	
Continuing Education: Minimum 6 hrs annually 333-536-0070(5)	
If CG provides medication administration: One additional hour of CE related to medications 333-536-0070(5)	
Criminal records check vendor's name & state where business located:	
If Oregon DHS Background Check Unit is not used, the CRC vendor meets qualifying criteria in 333-536-0093: (6)(b)(A) Accredited by the National Association of Professional Background Screeners (NAPBS) OR (6)(b)(B) (i) Has been in business for at least 2 yrs; (ii) Has a current business license & private investigator license if required in the company's home state; and (iii) Maintains an errors and omissions insurance policy in an amount not less than \$1 million.	
If hire date on or after October 1, 2012 was criminal records check completed prior to hire date? 333-536-0093(2)	
If hire date before October 1, 2012 was CRC completed as required? 333-536-0093(12)(13)	
CRC includes required elements: 333-536-0093(8) Name & address history trace conducted	
Records correctly identified via date of birth and social security number trace	
Local check conducted, including city and county records for last seven years	
Nationwide multi-jurisdictional search, including state and federal records	
Nationwide sex offender registry search completed	
Name & contact information of vendor	
Arrest, warrant & conviction data including charges, jurisdiction, & date	
LEIE (List of Excluded Individuals and Entities) query conducted and documented? 333-536-0093(9)	
Were there ORS 443.004(3) crimes identified? 333-536-0093(3)	
If crimes other than ORS 443.004(3), or if other potentially disqualifying conditions were identified, was weighing test conducted and documented? 333-536-0093(4)	

IN-HOME CARE SURVEY
CLIENT Record Review

Agency: _____ Date: _____ Surveyor: _____ Client #: _____

Name of Client:	
Start of Service Date:	
Client's Date of Birth:	M <input type="checkbox"/> F <input type="checkbox"/>
Significant diagnoses, conditions, or problems:	
<p>Disclosure Statement & Clients Rights: Accurate/complete, signed/dated by client or rep, and includes: 333-536-0055(2)</p> <p>(a) A description of the license classification, services offered by the agency, extent of registered nurse involvement in the agency's operations and whether nursing services as described in OAR 333-536-0080 are provided;</p> <p>(b) If the agency provides medication reminding or medication services, the qualifications of the individual(s) providing oversight of the agency's medication administration systems and the medication training and demonstration;</p> <p>(c) A clear statement indicating that it is not within the scope of the agency's license to manage the medical and health conditions of clients who are no longer stable or predictable;</p> <p>(d) The qualifications /training requirements determined by the agency for individuals providing direct client care;</p> <p>(e) The charges for the services provided by the agency;</p> <p>(f) A description of how the service plans are developed and reviewed and the relationship between the service plans and the cost of services;</p> <p>(g) A description of billing methods, payment systems, and due dates;</p> <p>(h) The policy for client notification of increases in the costs of services;</p> <p>(i) The agency's refund policy;</p> <p>(j) Criteria, circumstances, conditions which may result in termination of services by the agency and client notification of such;</p> <p>(k) Procedures for contacting agency administrator or designee during all of the hours during which services are provided; and</p> <p>(l) A copy of the client's rights as written in OAR 333-536-0060.</p>	
<p>Client's Rights included as written: An agency shall provide each client with a written notice of the client's rights as a part of the disclosure statement, prior to furnishing care to a client. 333-536-0060(1)(a-m)</p>	
<p>Client's rights additional requirements: 333-536-0060(2)</p> <p>The client's rights notice shall also include:</p> <p>(a) Procedures for filing a grievance or complaint with the agency;</p> <p>(b) Procedures for filing a grievance or complaint with the Division, along with the telephone number and contact information of the Division; and</p> <p>(c) Notice that the Division has the authority to examine clients' records as part of the Division's regulation and evaluation of the agency.</p>	
<p>Initial Assessment of the Client's mental, physical and emotional health: Documented, dated and signed. 333-536-0065(1)</p>	

<p>Current Service Plan: Completed within 7 days of initiation of service, list of individuals participating in the plan, signature and date of administrator or administrator designee. 333-536-0065(2)</p>	
<p>Current Service Plan: Includes the schedule for the provision of services (range of hrs/mnth). 333-536-0065(3)(a)</p>	
<p>Current Service Plan: Specifies client-specific tasks to be conducted. 333-536-0065(3)(b)</p>	
<p>Current Service Plan: Includes pertinent information about client's function and needs. 333-536-0065(3)(c)</p>	
<p>Current Service Plan Changes: Changes to service plan documented and communicated. 333-536-0065(4)</p>	
<p>Names of CGs for client: List individuals providing services for this client</p>	

<p>Medication Reminders: Is this client receiving medication reminders?</p>	<p>Circle one: YES NO (skip next question)</p>
<p>Self-Direct Medication Reminder form: If provided, is client evaluated at start of service and every 90 days. 333-536-0045(1-3)</p>	
<p>Initial Site Visit: Conducted between the 7th and 30th day after start of service. 333-536-0065(6)</p>	
<p>Monitoring Visits: Conducted quarterly, dated/signed by admin or designee. List dates. 333-536-0065(7-8)</p>	
<p>Monitoring Visits: Documentation reflects whether: 333-536-0065(9) (a) Appropriate and safe techniques have been used in the provision of care; (b) The service plan has been followed as written; (c) The service plan is meeting the client's needs or needs to be updated; (d) The caregiver has received sufficient training for the client; (e) The client is satisfied with his or her relationship with the caregiver(s); and (f) Appropriate follow-up is necessary for any identified issues or problems.</p>	
<p>Documentation of all services provided: Paper and electronic records reflect provisions of all services. 333-536-0085(3-4)</p>	

<p>If Medication Services provided complete this section:</p>	<p>Circle one: Assistance Administration Set-up Only</p>
<p>Medication Services reflected in Service Plan: Service plan specifies the medication services and tasks to be provided and who is responsible for the tasks. 333-536-0075(5)</p>	
<p>Medication Set-up by client or family: Signed agreement from client, rep or family, includes list of medications and physical description of each with special instructions. 333-536-0075(2)</p>	
<p>Medication Services Physician Orders: Written and telephone orders accurate/complete and appropriately signed and dated. 333-536-0075(3)</p>	
<p>All Medication Services documented: Paper and electronic records reflect provision of all medication tasks and services including filling of secondary containers (set-up) and medication assistance. 333-536-0075(8)</p>	
<p>Medication Administration documented on MARs to include for EACH medication at least: 333-536-0075(6) *Name with strength; *Dosage; *Route; *Frequency; *Client specific instructions for PRNs; and *Other special instructions necessary for safe and appropriate administration. *The MAR shall also identify and list the client's medication allergies and sensitivities.</p>	
<p>Medication Services: Integrity and security of narcotics and controlled substances maintained and documented. 333-536-0075(4)(e)</p>	
<p>RN Evaluation of client's med regimen: Conducted & documented every 90 days 333-536-0075(9)</p>	

If Nursing Services provided complete this section:	<u>Circle all that apply:</u> RN provides LPN provides CG provides del. tasks
Nursing Services reflected in Service Plan: Service plan specifies the nursing services tasks to be provided and who responsible for tasks. 333-536-0080(1)	
Nursing Services Physician Orders: Written and telephone orders accurate/complete and appropriately signed and dated. 333-536-0080(5)	
Nursing Services documented: Paper and electronic records reflect provision of all nursing tasks and services including those provided by RNs, LPNs, and delegated tasks by CGs. 333-536-0085(4)	
When Delegated Tasks provided: Name of RN responsible for the delegation. Caregiver and specified delegated task(s) on service plan. 333-536-0080(2-3)	
RN Delegation doc. per OSBN OARs in Chapter 851, Division 047, including: *Assessment of client condition; *Rationale for deciding that the task of nursing care can be safely delegated; *Skills, ability and willingness of the unlicensed person; *Teaching of the task to the unlicensed person; *The written instructions left for the unlicensed person; *Evidence that the unlicensed person was instructed that the task is client specific and not transferable to any other client; *How frequently the client should be re-assessed by the RN for continued delegation; *How frequently the unlicensed person should be supervised and re-evaluated by the RN; *A statement that the RN takes responsibility for delegation of the task to the unlicensed person and for continued supervision. OSBN OARs in Chapter 851, Division 047 OAR 333-536-0080(2)	
RN Reassessment of client and Supervision/Reevaluation of CG: *Within 60 days of initial delegation; *Thereafter at intervals at intervals not longer than 180 days. OSBN OARs in Chapter 851, Division 047	
Changes to Delegation of Tasks: Delegations rescinded or transferred in accordance with	

IN-HOME CARE SURVEY
QAPI/Complaint Process Review

Agency _____ Date _____ Surveyor _____

Agency Staff Interviewed _____

1. Quality Assessment and Performance Improvement Program

Met	Not Met	Requirement(s)	Notes
<input type="checkbox"/>	<input type="checkbox"/>	QAPI Program: establish and maintain an effective, agency wide quality assessment and performance improvement program that evaluates and monitors the quality, safety and appropriateness of services provided by the agency, and shall include at a minimum: 333-536-0090(1-4)	
<input type="checkbox"/>	<input type="checkbox"/>	A method to identify, analyze and correct adverse events;	
<input type="checkbox"/>	<input type="checkbox"/>	A method to select and track quality indicators by high risk, high volume, problem prone areas and by the effect on client safety and quality of care;	
<input type="checkbox"/>	<input type="checkbox"/>	The quality improvement activities shall be conducted by a committee comprised of, at a minimum, agency administrative staff, an agency caregiver, and if the agency is classified as an intermediate or comprehensive agency, an agency registered nurse; and	
<input type="checkbox"/>	<input type="checkbox"/>	Quality improvement activities shall be conducted and documented at least quarterly.	

2. Complaint and Grievance Process

Met	Not Met	Requirement(s)	Notes
<input type="checkbox"/>	<input type="checkbox"/>	Complaint Process: Ensuring the timely internal investigation of complaints, grievances, accidents, incidents, medication or treatment errors, and allegations of abuse or neglect involving individuals providing services for the agency 333-536-0050(8)(i)	
<input type="checkbox"/>	<input type="checkbox"/>	An agency shall maintain in its records documentation of the complaint or event,	
<input type="checkbox"/>	<input type="checkbox"/>	the investigation,	
<input type="checkbox"/>	<input type="checkbox"/>	the results, and	
<input type="checkbox"/>	<input type="checkbox"/>	actions taken	
<input type="checkbox"/>	<input type="checkbox"/>	Complaint Process: Ensuring the timely reporting of allegations of abuse or neglect to the appropriate authority 333-536-0050(8)(j)	
<input type="checkbox"/>	<input type="checkbox"/>	the Department of Human Services,	
<input type="checkbox"/>	<input type="checkbox"/>	Oregon Health Authority,	
<input type="checkbox"/>	<input type="checkbox"/>	Public Health Division,	
<input type="checkbox"/>	<input type="checkbox"/>	local law enforcement agency, or	
<input type="checkbox"/>	<input type="checkbox"/>	other	



Health Facility Licensing and Certification

800 NE Oregon Street, Suite 465

Portland, Oregon 97232

971-673-0540

971-673-0556 (Fax)

To: Oregon In-home care agencies

From: Health Facility Licensing and Certification (HFLC) In-home care agency (IHC) program

RE: In-home care statement of deficiency and plan of correction guidance

The purpose of this memo is to provide guidance regarding statement of deficiency reports and the plan of correction response.

The Oregon Administrative Rule (OAR) 333-536-0117

What happens after a survey?

- ⇒ **Statement of Deficiency (SOD) Report is sent by the state surveyor to the agency (see attachment 1)**
 - Sent within 10 business days from the survey exit date, includes a cover letter which gives directions.
- ⇒ **Plan of Correction (POC) response is sent by the agency to address the SOD report (see attachment 2)**
 - Sent within 10 business days from receipt of the SOD, includes the first page of the SOD signed by the administrator.
 - Each deficiency must be addressed and include the following information:
 - ◆ The plan for correcting the specific deficiency;
 - ◆ The procedure(s) for implementing the plan for the specific deficiency;
 - ◆ The monitoring procedure(s);
 - ◆ The title of the person designated as responsible for implementing the plan; and
 - ◆ The completion date for correction of each deficiency cited.

Plan of Correction (POC) tips:

- ⇒ The plan of correction information can be put on the actual state of deficiencies or on a separate piece of paper.
- ⇒ Always include the first page of the SOD, signed and dated by the administrator.
- ⇒ Make sure you are addressing all 5 of the required POC elements.
- ⇒ The plan of correction should address the deficiency, not the findings.
- ⇒ If you are having problems completing the POC before the deadline, please contact the surveyor for a possible extension.

What can an agency do to prepare for a relicensure survey?

- ⇒ Practice running the required lists and gathering the required information:
 - A list of all caregivers and nurses who provide any services for the past twelve months, including branches, with the date of hire and position held.
 - A list of all clients who received any services during the past twelve months, including branches, with the start of service date and service level provided.
 - All complaint, incident, accident, and error reports (including medication errors) for the past twelve months, including the follow-up and resolution documentation.
 - Quality improvement program plan and all activity for the past three years.
 - Current, written policies and procedures.
 - Orientation, training curriculums, and competency evaluation materials.
- ⇒ Read the Oregon Administrative Rules:
 - The rules (Chapter 333, Division 536) are available online www.healthoregon.org/hflc.
- ⇒ Read the guidance information available online:
 - The information and memos are in the licensure and application information section www.healthoregon.org/hflc.
- ⇒ Use the survey relicensure tools for file audits:
 - The tools are available online www.healthoregon.org/hflc.

If you have any questions please email the IHC survey team at mailbox.hclc@state.or.us.

Ms. Jane Example, Administrator
Example In Home Care
800 NE Oregon Street
Portland, Oregon 97232

Dear Ms. Example:

Enclosed is the Statement of Deficiencies for the State relicensing survey completed on April 18, 2016.

You must complete and sign the Plan of Correction and return it to our office within ten (10) business days of your receipt of this letter. Please keep a copy for your files. The plan of correction must include the following information for each deficiency cited:

1. The plan for correcting the specific deficiency. The plan should include specific corrective actions and should address the processes that caused or contributed to the deficient practice;
2. The procedure(s) for implementing the plan for the specific deficiency;
3. The monitoring procedure(s) to ensure the plan of correction for the specific deficiency is effective in achieving and maintaining compliance with the regulatory requirements;
4. The title of the person designated as responsible for implementing the plan for the specific deficiency; and
5. The completion date for correction of each deficiency cited. Although each deficiency should be corrected as soon as reasonably possible, the correction date may be up to sixty (60) days from the survey exit date. Permission to take longer than sixty (60) days to correct deficiencies requiring major construction or remodeling may be granted by this office. A

request for such an extension must be submitted in writing and accompany the plan of correction.

Please note that the administrator's signature and the date signed must be recorded on page 1 of the Statement of Deficiencies.

If you have any questions, please call our office at (971) 673-0540. Thank you for your cooperation.

Sincerely,

HFLC IHC Surveyor Client Care Surveyor
Oregon Health Authority
Public Health Division
Health Facility Licensing and Certification

Enclosures

If you need this information in an alternate format, please call our office at (971) 673-0540 or TTY (971) 673-0372

Health Facility Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 15-0000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 01/18/2016
NAME OF PROVIDER OR SUPPLIER Example In-Home Care		STREET ADDRESS, CITY, STATE, ZIP CODE 800 NE OREGON ST PORTLAND, OR 97232	

(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	1D PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A000	Initial Comments This report reflects the findings of the unannounced on-site survey for relicensure, completed on 04/18/2016. The agency was evaluated for compliance with the applicable Oregon Administrative Rules for "In Home-Care Agencies", Division 333, Chapter 536. This agency is licensed as a Comprehensive Classification agency. The following deficiencies were identified:			
A190	OAR 333-536-0093 (1-3) Criminal Records Check Define & Applicability (1) For the purposes of this section, the following definitions apply: (a) "Direct contact with" means to provide in-home care services and includes meeting in person with a potential or current client to discuss services offered by an agency or other matters relating to the business relationship between an agency and client; (b) "Disqualifying condition" means a non-criminal personal history issue that makes an individual unsuitable for employment, contracting or volunteering for an agency, including but not limited to discipline by a licensing or certifying agency, or drug or alcohol dependency; (c) " Subject individual " (SI) means an individual on whom an agency may conduct a criminal records check and from whom an agency may require fingerprints for the purpose of conducting a national criminal records check, including: (A) An employee or prospective employee; (B) A temporary worker, volunteer or owner of an agency who has direct contact with an agency client or potential client; and	A190		

STATE OF OREGON
LABORATORY DIRECTOR'S OR PROVIDER|SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Health Facility Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 15-0000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 01/18/2016
NAME OF PROVIDER OR SUPPLIER Example In-Home Care		STREET ADDRESS, CITY, STATE, ZIP CODE 800 NE OREGON ST PORTLAND, OR 97232	

(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	1D PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
A 190	<p>Continued from page 1</p> <p>(C) A prospective temporary worker, or volunteer or owner who may have direct contact with an agency client.</p> <p>(d) " Vendor " means a researcher or company hired to provide a criminal records check on a subject individual.</p> <p>(e) " Weighing test " means a process in which an agency considers available information to make a fitness determination when an SI has potentially disqualifying convictions or conditions.</p> <p>(2) An agency shall conduct a criminal records check before hiring an SI and before allowing an SI to volunteer to provide services on behalf of the agency, if an SI will have direct contact with a client of the agency.</p> <p>(3) An SI who has or will have direct contact with a recipient of in-home care services may not be employed or volunteer with an agency in any capacity if the criminal records check conducted reveals the SI has been convicted of a crime as described in ORS 443.004(3).</p> <p>This Rule is not met as evidenced by: Based on interview and review of documentation of 5 of 5 employee records (Employees 1, 2, 3, 4 and 5), it was determined that the agency failed to ensure that a Criminal Records Check (CRC) was conducted before the employee was hired, as required in Oregon Administrative Rule (OAR) 333-536-0093(2).</p> <p>Findings include:</p> <p>1. Review of the record for Employee 1 revealed a hire date of 10/26/2013. Documentation in the record revealed the CRC from the Department of</p>	A190		

STATE OF OREGON
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Health Facility Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 15-0000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 01/18/2016
NAME OF PROVIDER OR SUPPLIER Example In-Home Care		STREET ADDRESS, CITY, STATE, ZIP CODE 800 NE OREGON ST PORTLAND, OR 97232	

(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	1D PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 190	<p>Continued from page 2</p> <p>Human Service's Background Check Unit was dated 11/07/2013. The CRC was conducted twelve (12) days after the employee was hired.</p> <p>2. Review of the record for Employee 2 revealed a hire date of 06/07/2014. Documentation in the record revealed the CRC from the Department of Human Service's Background Check Unit dated 06/22/2014. The CRC was conducted fifteen (15) days after the employee was hired.</p> <p>3. Review of the record for Employee 3 revealed a hire date of 02/23/2014. Documentation in the record revealed the CRC from the Department of Human Service's Background Check Unit was dated 03/12/2014. The CRC was conducted seventeen (17) days after the employee was hired.</p> <p>4. Review of the record for Employee 4 revealed a hire date of 03/19/2013. Documentation in the record revealed the CRC from the Department of Human Service's Background Check Unit dated 04/03/2013. The CRC was conducted fifteen (15) days after the employee was hired.</p> <p>5. Review of the record for Employee 5 revealed a hire date of 12/15/2013. Documentation in the record revealed the CRC from the Department of Human Service's Background Check Unit was dated 12/30/2014. The CRC was conducted fifteen (15) days after the employee was hired.</p> <p>6. During an interview with the agency administrator designee on 04/18/2016, he/she verified that the CRC records reviewed were the only documents on file for the employee criminal history checks.</p>	A190		

STATE OF OREGON
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Health Facility Licensing and Certification

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A 190	Continued from page 3 7. These findings were shared with the agency administrator designee during the exit conference conducted on 04/18/2016 and no additional information was provided.	A190		

STATE OF OREGON
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

CONFIDENTIAL

Employee List (example only, not real people) Health Facility Licensing and Certification

Facility/Provider: Example In Home Care

Survey Date: April 18, 2016

Identifier	Name
1	Debra Allegory
2	Shane Illustration
3	Henry Likeness
4	Alice Relation
5	Edna Correlation
6	
7	
8	
9	
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14	
15	
16	
17	
18	
19	

CONFIDENTIAL

Client List (example only, not real people) Health Facility Licensing and Certification

Facility/Provider: Example In Home Care

Survey Date: April 18, 2016

Identifier	Name
1	Jane Doe
2	John Doe
3	Joe Person
4	Sally Client
5	Ellen Lastname
6	
7	
8	
9	
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11	
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14	
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19	

Health Facility Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 15-0000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 01/18/2016
NAME OF PROVIDER OR SUPPLIER Example In-Home Care		STREET ADDRESS, CITY, STATE, ZIP CODE 800 NE OREGON ST PORTLAND, OR 97232	

(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	1D PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A000	Initial Comments This report reflects the findings of the unannounced on-site survey for relicensure, completed on 04/18/2016. The agency was evaluated for compliance with the applicable Oregon Administrative Rules for "In Home-Care Agencies", Division 333, Chapter 536. This agency is licensed as a Comprehensive Classification agency. The following deficiencies were identified:			
A190	OAR 333-536-0093 (1-3) Criminal Records Check Define & Applicability (1) For the purposes of this section, the following definitions apply: (a) "Direct contact with" means to provide in-home care services and includes meeting in person with a potential or current client to discuss services offered by an agency or other matters relating to the business relationship between an agency and client; (b) "Disqualifying condition" means a non-criminal personal history issue that makes an individual unsuitable for employment, contracting or volunteering for an agency, including but not limited to discipline by a licensing or certifying agency, or drug or alcohol dependency; (c) " Subject individual " (SI) means an individual on whom an agency may conduct a criminal records check and from whom an agency may require fingerprints for the purpose of conducting a national criminal records check, including: (A) An employee or prospective employee; (B) A temporary worker, volunteer or owner of an agency who has direct contact with an agency client or potential client; and	A190	Please see attached sheet for Plan of Correction	

STATE OF OREGON
LABORATORY DIRECTOR'S OR PROVIDER|SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Signature of Administrator or Designee

April 18, 2016

Example In-Home Care Plan of Correction

TAG 0190

1. The plan for correcting the specific deficiency. The plan should include specific corrective actions and should address the processes that caused or contributed to the deficient practice:

I did not change the policy regarding criminal history checks when the new rules went into effect on October 01, 2012. Consequently, the human resources director was following the old policy which allows a caregiver to be hired before the criminal history check report is sent to the agency. Caregivers were not allowed to provide history check report is sent to the agency. Caregivers were not allowed to provide services, but were allowed to go through training. Examples in home care will ensure that a criminal records check has been conducted and passed before any caregiver is hired.

2. The procedure(s) for implementing the plan for the specific deficiency:

The procedures to correct this error include editing the current criminal history policy and procedure to state that all caregivers must pass a criminal history check, conducted by the agency, before they can be hired. The pre-hire checklist form will be edited to include the criminal history check. The agency is going to conduct an all staff meeting to discuss the change.

3. The monitoring procedure(s) to ensure the plan of correction for the specific deficiency is effective in achieving and maintaining compliance with the regularity requirements:

The administrator must sign off on all criminal history checks before HR continues with the hiring process. The agency is going to audit the pre-hire checklists quarterly and incorporate the finding into the quality improvement program.

4. The title of the person designated as responsible for implementing the plan for the specific deficiency:

The agency administrator

5. The completion date for the correction of each deficiency cited:

05/01/2016