

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	<p>This was a Home Health federal recertification survey. This was a partial extended survey.</p> <p>Survey Dates: January 2, 3, 4, and 7, 2013 Partial Extended Survey Date: January 4, 2013</p> <p>Facility Number: IN005332</p> <p>Medicaid Number: 100264360A</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census Service Type: Skilled: 431 Home Health Aide Only: 20 Personal Care Only: 11 Total: 462</p> <p>Sample: RR w/HV: 6 RRw/o HV: 6 Total: 12</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN  January 10, 2013</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
G0116	<p><b>484.10(f)</b> <b>HOME HEALTH HOTLINE</b> The patient has the right to be advised of the availability of the toll-free HHA hotline in the State.</p> <p>When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.</p> <p>Based on clinical record review, document review, and interview, the agency failed to ensure the patients' rights included the correct phone number for the Home Health Complaint Hotline for 12 of 12 records reviewed with the potential to affect all the agency's patients. (#6)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The Patient's Rights and Responsibilities form included in the agency's admission packet failed to contain the proper phone number for the Indiana Home Health Complaint Hotline.</li> <li>Clinical records 1-12 evidenced the patient had received the admission packet.</li> </ol> <p>During home visit with patient #6 on</p>	G0116	Initiated new Home Care Patient's Rights and Responsibilities document. The document ensures patients are informed in writing of the telephone number of the home health hotline established by the state, the hours of operation, and that the purpose of the hotline is to receive complaints or questions about local HHA's and the implementation of the advance directives requirements. The Director of Home Care has educated all Home Care staff regarding the new Home Care Patient's Rights and Responsibilities document.	01/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>1/4/13 at 1:00 PM, the patient admission folder which included the patient's rights failed to include the correct phone number for the Indiana Home Health Complaint Hotline. At 1:10 PM, patient #6 indicated they knew there was a complaint number and had called it in the past when they were with another agency.</p> <p>3. On 1/2/13 at 2:30 PM, employee B indicated the phone number listed in the patient rights was questioned during last survey and was incorrect at that time also.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
G0121	<p><b>484.12(c)</b> <b>COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</b> The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on clinical record and document review and interview, the agency failed to ensure the skilled nurse (SN) assessed the patient's wound status in accordance with professional standards for 2 of 12 records reviewed with the potential to affect all the agency's patients. (#5 and 10)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record #5, Start of Care (SOC) 12/11/12, contained a plan of care for the certification period 12/11/12 to 2/8/13 that identified the patient had pressure ulcers with physician orders for the SN to visit 2 times a week times 5 weeks. The nurse was to complete a complete systems assessment which included under Skin Integrity Impairment/Risk to Assess wound site for signs and symptoms of infection and other complications. SN Visit Records dated 12/18 and 12/20/12 failed to evidence the wound was measured.</li> <li>Clinical record #10, SOC 4/19/12, contained a plan of care for the</li> </ol>	G0121	<p>Policy titled "Wound Care Guidelines - initiated on 1/17/13: all patient's with nonsurgical wounds will have wounds measured and observed for signs and symptoms of infection and/or deterioration atleast weekly. These measurements will be documented in patients medical records. Agency implemented quality process: wound care certified RN to monitor that policy is being followed by agency staff. The Director of Home Care will be responsible for insuring that the quality process initiative is being followed. The Director of Home Care has educated all Home Care staff regarding new Wound Care Guideline policy and quality process.</p>	01/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>certification period 6/18/12/ to 8/16/12 that identified the patient had pressure ulcers and with physician orders the SN to visit 3 times a week for 8 weeks then 2 times a week for 1 week. The nurse was to complete a complete systems assessment which included under Skin Integrity Impairment/Risk to Assess skin integrity, wound status at each treatment; Assess wound site for signs and symptoms of infection and other complications. SN Visit Records dated 7/2/12 and 7/5/12 failed to evidence the wound was measured.</p> <p>3. A document titled Pressure Ulcer Assessment and Treatment, copyright 2011 wild Iris Medical Education, Inc, accessed at <a href="http://www.nursingceu.com/courses/343/index_nceu.html">www.nursingceu.com/courses/343/index_nceu.html</a>, states, under Documenting the Wound Status, "Documentation for pressure ulcer management includes an assessment of the ulcer on admission and at least weekly ... for any signs of skin and/or wound deterioration .... The following should be included in the documentation of any wound: ... wound measurements ...."</p> <p>4. On 1/4/12 at 2:50 PM, employee B indicated the expectation is that wounds be measured weekly, but the agency does not have a written policy.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0134	<p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. Based on employee file review and interview, the administrator failed to ensure all employees had an annual evaluation for 1 of 9 employee files reviewed. (A)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Employee file A, a Registered Nurse and alternate administrator, date of hire 1/9/95, failed to evidence an annual evaluation had been completed since 2010.</li> <li>2. On 1/7/13 at 11:45 AM, employee B indicated they asked employee A if one had been received in 2012 and employee A told them no. Employee B indicated it could not be located, so it must not have been completed.</li> </ol>	G0134	The employees annual evaluation was completed by the Director of Home Care agency. New computer system initiated on 1/7/13 which will alert Director that employee evaluations are due three weeks prior to due date. The Director of Home Care will be responsible for insuring the timely completion of all employee's annual evaluations.	01/17/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
G0135	<p><b>484.14(c) ADMINISTRATOR</b> The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, ensures the accuracy of public information materials and activities.</p> <p>Based on document review and interview, the agency's administrator failed to ensure the accuracy of public information for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 1/2/13 at 9:20 AM, employee B indicated there was a name change for DeKalb Hospital in June of 2011 to DeKalb Health and the home health agency is a department of the hospital so the new name will be DeKalb Health Home Care. At 11:00 AM, employee provided a copy of the letter sent to Indiana State Department of Health (ISDH) dated 6/24/11 stating DeKalb Memorial Hospital is Doing Business As (D.B.A.) DeKalb Health. This letter failed to evidence the home health agency had changed its name. Employee B indicated the home health agency is still operating under DeKalb Memorial Hospital Home Health Services but are marketing as DeKalb Health Home Care.</li> <li>On 1/2/13 at 10:15 AM, Indiana State</li> </ol>	G0135	<p>Director of Home Care agency sent letter to the Indiana State Department of Health Acute Care Division dated 6/24/11 informing the state that DeKalb Memorial Hospital is now D.B.A DeKalb Health and DeKalb Memorial Home Health Care and Hospice is a department of DeKalb Health. A copy of the State of Indiana Office of the Secretary of State Certificate of assumed business name was enclosed. Director of Home Care agency spoke with Indiana State Department of Health on 10/1/12 regarding information located on agencies Fiscal Intermediary-PGBA. On 10/1/12 agency was instructed to complete 855A form located on the CMS.Gov website. On 10/9/12 Director of Home Care Agency completed the CMS 855a form and sent to PGBA with confirmation that document was received on 10/23/12. On 11/6/12 Director of Home Care agency received letter from Palmetto GBA that Palmetto GBA is not the medicare contractor that services your geographic location. Resubmit your application to Wisconsin Physicians Service in Omaha NE. Director of Home Care</p>	01/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Department of Health (ISDH) staff indicated there had not been a name change notification to ISDH as of 1/2/13.</p> <p>3. Admission packet documents labeled with the name DeKalb Health Home Care included admission packet letter, Home Health Consolidated Billing form, Do Not Resuscitate/Do Not Intubate Consent/Authorization form, Authorization for Verbal Communication form, Patient Medication Profile, Medication Reconciliation form, Coumadin Flow Sheet, How to reach a nurse form for patient to post in home, Medicare Face-to-Face letter, Private Pay Rates sheet, Universal Precautions and Patients' Rights sheet, and Emergency Preparedness sheet.</p> <p>4. Clinical records forms labeled with name DeKalb Health Home Care included Home Health Certification and Plan of Care and Skilled Nurse Visit Record.</p> <p>5. On 1/7/13 at 3:35 PM, employee J indicated the home health agency is keeping the name DeKalb Memorial Hospital Home Health Services but is doing business as DeKalb Health Home Care.</p>		<p>agency submitted CMS 855a form to Wisconsin Physicians Service on 11/23/12 with confirmation that document was received on 11/27/12. 11/9/12 Director of Home Care agency spoke with PGBA, Lorraine, regarding agencies contractor. Director of Home Care agency was directed to Shelly at WPS Medicare Part A, contact was made with WPS and instructed would need to wait WPS processing 855a. Director of Home Care agency spoke with Amy Otten on 12/10/12 at WPS and was instructed that additional information was required. Director of Home Care agency provided Amy Otten at WPS with requested information via scanned document on 12/10/12. Director of Home Care agency was emailed by Amy Otten at WPS on 1/11/13 regarding the need for further information to complete the 855a application. Director of Home Care agency scanned required documents on 1/11/13 to Amy Otten at WPS. Director of Home Care agency received email dated 1/14/13 from Amy Otten at WPS requesting further information to complete Home Care agencies 855 application. Director of Home Care agency scanned required information to Amy Otten on 1/14/13. Director of Home Care agency received email from Amy Otten at WPS on 1/15/13 requesting further</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			information and need to update NPPES. Director of Home Care agency scanned requested information to Amy Otten on 1/15/13 and NPPES was updated. 1/16/13 Director of Home Care agency received email from Amy Otten requesting further information to complete 855 application, Director of agency scanned information to Amy Otten on 1/16/13. 1/16/13 Amy Otten emailed that all information has been received with need for NPI registry to be checked am of 1/17/13 and then she will submit the application for review. Amy Otten states once application is processed a letter will be sent to the Home Care agency and to the Indian State Department of Health. 1/18/13 Director of Home Care agency will remove marketing, patient admission packet documents, clinical record forms, home care certification and plan of care with the name of DeKalb Health Home Care. Marketing and all documents will be labeled DeKalb Memorial Hospital Home Health Services. Director of Home Care will continue to work with CMS and the Secretary of State to complete agencies D.B.A with official notification to the Indiana State Department of Health upon completion.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2013
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0000	<p>This was a Home Health state licensure survey.</p> <p>Survey Dates: January 2, 3, 4, and 7, 2013</p> <p>Facility Number: IN005332</p> <p>Medicaid Number: 100264360A</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census Service Type: Skilled: 431 Home Health Aide Only: 20 Personal Care Only: 11 Total: 462</p> <p>Sample: RR w/HV: 6 RRw/o HV: 6 Total: 12</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 10, 2013</p>	N0000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0446	<p>410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3)</p> <p>Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on employee file review and interview, the administrator failed to ensure all employees had an annual evaluation for 1 of 9 employee files reviewed. (A)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Employee file A, a Registered Nurse and alternate administrator, date of hire 1/9/95, failed to evidence an annual evaluation had been completed since 2010.</li> <li>On 1/7/13 at 11:45 AM, employee B indicated they asked employee A if one had been received in 2012 and employee A told them no. Employee B indicated it could not be located, so it must not have been completed.</li> </ol>	N0446	The employees annual evaluation was completed by the Director of Home Care. New computer system initiated on 1/7/13 which will alert Director that employee evaluations are due three weeks prior to due date. The Director of Home Care will be responsible for insuring the timely completion of all employee's annual evaluations.	01/17/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
N0447	<p>410 IAC 17-12-1(c)(4) Home health agency administration/management Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities.</p> <p>Based on document review and interview, the agency's administrator failed to ensure the accuracy of public information for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. On 1/2/13 at 9:20 AM, employee B indicated there was a name change for DeKalb Hospital in June of 2011 to DeKalb Health and the home health agency is a department of the hospital so the new name will be DeKalb Health Home Care. At 11:00 AM, employee provided a copy of the letter sent to Indiana State Department of Health (ISDH) dated 6/24/11 stating DeKalb Memorial Hospital is Doing Business As (D.B.A.) DeKalb Health. This letter failed to evidence the home health agency had changed its name. Employee B indicated the home health agency is still operating under DeKalb Memorial Hospital Home Health Services but are marketing as DeKalb Health Home Care.</p>	N0447	<p>Director of Home Care agency sent letter to the Indiana State Department of Health Acute Care Division dated 6/24/11 informing the state that DeKalb Memorial Hospital is now D.B.A DeKalb Health and DeKalb Memorial Home Health Care and Hospice is a department of DeKalb Health. A copy of the State of Indiana Office of the Secretary of State Certificate of assumed business name was enclosed. Director of Home Care agency spoke with Indiana State Department of Health on 10/1/12 regarding information located on agencies Fiscal Intermediary-PGBA. On 10/1/12 agency was instructed to complete 855A form located on the CMS.Gov website. On 10/9/12 Director of Home Care Agency completed the CMS 855a form and sent to PGBA with confirmation that document was received on 10/23/12. On 11/6/12 Director of Home Care agency received letter from Palmetto GBA that Palmetto GBA is not the medicare contractor that services your geographic location. Resubmit your application to Wisconsin</p>	02/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2013	
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2. On 1/2/13 at 10:15 AM, Indiana State Department of Health (ISDH) staff indicated there had not been a name change notification to ISDH as of 1/2/13.</p> <p>3. Admission packet documents labeled with the name DeKalb Health Home Care included admission packet letter, Home Health Consolidated Billing form, Do Not Resuscitate/Do Not Intubate Consent/Authorization form, Authorization for Verbal Communication form, Patient Medication Profile, Medication Reconciliation form, Coumadin Flow Sheet, How to reach a nurse form for patient to post in home, Medicare Face-to-Face letter, Private Pay Rates sheet, Universal Precautions and Patients' Rights sheet, and Emergency Preparedness sheet.</p> <p>4. Clinical records forms labeled with name DeKalb Health Home Care included Home Health Certification and Plan of Care and Skilled Nurse Visit Record.</p> <p>5. On 1/7/13 at 3:35 PM, employee J indicated the home health agency is keeping the name DeKalb Memorial Hospital Home Health Services but is doing business as DeKalb Health Home Care.</p>		<p>Physicians Service in Omaha NE. Director of Home Care agency submitted CMS 855a form to Wisconsin Physicians Service on 11/23/12 with confirmation that document was received on 11/27/12. 11/9/12 Director of Home Care agency spoke with PGBA, Lorraine, regarding agencies contractor. Director of Home Care agency was directed to Shelly at WPS Medicare Part A, contact was made with WPS and instructed would need to wait WPS processing 855a. Director of Home Care agency spoke with Amy Otten on 12/10/12 at WPS and was instructed that additional information was required. Director of Home Care agency provided Amy Otten at WPS with requested information via scanned document on 12/10/12. Director of Home Care agency was emailed by Amy Otten at WPS on 1/11/13 regarding the need for further information to complete the 855a application. Director of Home Care agency scanned required documents on 1/11/13 to Amy Otten at WPS. Director of Home Care agency received email dated 1/14/13 from Amy Otten at WPS requesting further information to complete Home Care agencies 855 application. Director of Home Care agency scanned required information to Amy Otten on 1/14/13. Director of Home Care agency received</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p>email from Amy Otten at WPS on 1/15/13 requesting further information and need to update NPPES. Director of Home Care agency scanned requested information to Amy Otten on 1/15/13 and NPPES was updated. 1/16/13 Director of Home Care agency received email from Amy Otten requesting further information to complete 855 application, Director of agency scanned information to Amy Otten on 1/16/13. 1/16/13 Amy Otten emailed that all information has been received with need for NPI registry to be checked am of 1/17/13 and then she will submit the application for review. Amy Otten states once application is processed a letter will be sent to the Home Care agency and to the Indian State Department of Health. 1/18/13 Director of Home Care agency will remove marketing, patient admission packet documents, clinical record forms, home care certification and plan of care with the name of DeKalb Health Home Care. Marketing and all documents will be labeled DeKalb Memorial Hospital Home Health Services. Director of Home Care will continue to work with CMS and the Secretary of State to complete agencies D.B.A with official notification to the Indiana State Department of Health upon completion.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2013	
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
N0458	<p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:</p> <p>(1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations.</p> <p>Based on employee file and policy review and interview, the agency failed to ensure the criminal background check was completed within three days of first patient contact and annual evaluations were completed for all employees for 2 of 9 employee files reviewed. (A and G)</p> <p>Findings include:</p> <p>1. Employee file A, a Registered Nurse and alternate administrator, date of hire 1/9/95, failed to evidence an annual evaluation had been completed since 2010.</p> <p>On 1/7/13 at 11:45 AM, employee B indicated they asked employee A if one</p>	N0458	The employees annual evaluation was completed by the Director of Home Care. New computer system initiated on 1/7/13 which will alert Director that employee evaluations are due three weeks prior to due date. The Director of Home Care will be responsible for insuring the timely completion of all employee's annual evaluations. Contracted therapies will not work with Home Care patients until they have a criminal back ground check via Indiana State Police Repository. Dekalb Health human resource department will schedule all contracted therapies for orientation, completion of Criminal background check and physical. The Director of Home Care will verify that a criminal	02/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>had been received in 2012 and employee A told them no. Employee B indicated it could not be located, so it must not have been completed.</p> <p>2. Employee file G, an Occupational Therapist, date of hire 5/1/08, first patient contact date 5/5/08, failed to evidence a criminal background check had been completed via the Indiana State Police Repository. A letter dated 5/6/08 evidenced a background search was conducted on May 6, 2008, but failed to evidence where the information was found.</p> <p>A. At 12:45 PM on 1/7/13, employee B indicated the company TherEx who occasionally provides physical and occupational therapists runs the background checks. A letter from TherEx dated 1/7/13 was provided stating they contract with Kroll Background Screening and what the background checks include. This letter failed to evidence the company checked the Indiana State Police Repository.</p> <p>B. On 1/7/13 at 1:45 PM, employee B indicated they do not have any other criminal background check.</p> <p>C. The agency's policy titled "Limited Criminal History of Employees," number</p>		background check has been completed for the contracted therapist prior to patient contact.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	XIII-008, reviewed 03/01/11, states "DeKalb Memorial Hospital will obtain a limited criminal history investigation for <u>all new employees</u> , regardless of the department in which they will be working."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0462	<p>410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on employee file and policy review and interview, the agency failed to ensure all employees with direct patient contact had a physical that was completed within 180 days prior to first patient contact date for 1 of 9 employee files reviewed. (G)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Employee file G, an Occupational Therapist, date of hire 5/1/08, first patient contact date 5/5/08, contained a physical dated 10/2/2008.</li> <li>2. On 1/7/13 at 1:45 PM, employee B indicated they do not have a newer physical for employee G.</li> <li>3. The agency's policy titled "Medical Examination," number HR-006, reviewed 03/2011, states "Successful applicants for employment may be required, as a</li> </ol>	N0462	Contracted therapies will not work with Home Care patients until they have completed a physical examination. DeKalb Health human resource department will schedule all contracted therapies for orientation, completion of Criminal background check and physical examination. The Director of Home Care will verify a physical examination has been completed for the contracted therapist prior to patient contact.	02/15/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------------	--	---------------------	--	----------------------------

	condition of employment, to take a medical examination to establish their fitness to perform the jobs for which they have applied... ."			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
N0502	<p>410 IAC 17-12-3(b)(2)(C) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (C) Place a complaint with the department regarding treatment or care furnished by a home health agency. Based on clinical record review, document review, and interview, the agency failed to ensure the patients' rights included the correct phone number for the Home Health Complaint Hotline for 12 of 12 records reviewed with the potential to affect all the agency's patients. (#6)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The Patient's Rights and Responsibilities form included in the agency's admission packet failed to contain the proper phone number for the Indiana Home Health Complaint Hotline.</li> <li>Clinical records 1-12 evidenced the patient had received the admission packet.</li> </ol> <p>During home visit with patient #6 on 1/4/13 at 1:00 PM, the patient admission folder which included the patient's rights failed to include the correct phone number for the Indiana Home Health Complaint Hotline. At 1:10 PM, patient #6 indicated they knew there was a</p>	N0502	Initiated new Home Care Patient's Rights and Responsibilities document. The document ensures patients are informed in writing of the telephone number of the home health hotline established by the state, the hours of operation, and that the purpose of the hotline is to receive complaints or questions about local HHA's and the implementation of the advance directives requirements. The Director of Home Care has educated all Home Care staff regarding the new Home Care Patient's Rights and Responsibilities document.	01/17/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>complaint number and had called it in the past when they were with another agency.</p> <p>3. On 1/2/13 at 2:30 PM, employee B indicated the phone number listed in the patient rights was questioned during last survey and was incorrect at that time also.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
N0597	<p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry. Based on employee file review and interview, the agency failed to ensure the Home Health Aide (HHA) was on and in good standing on the Indiana State Aide Registry for 1 of 3 HHA files reviewed with the potential to affect all the agency's patients receiving HHA services. (I)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Employee file I, date of hire 10/8/12, first patient contact date 10/17/12, failed to evidence the agency had ascertained the aide was on and in good standing on the State Aide registry. The file also failed to evidence the agency had placed the HHA on the state aide registry.</li> <li>On 1/7/13 at 12:30 PM, employee B indicated this HHA came from another agency and was already a HHA so the agency completed testing and skills competency on employment. At 1:00 PM, employee B indicated they checked the State Aide Registry and did not find employee I on the list. The agency had not placed the aide on the registry.</li> </ol>	N0597	The Director of Home Care completed the Indiana State Aide Registry 1/7/13 with faxed verification provided to surveyor prior to exit interview. The Director will be responsible for checking the Indiana State Aide Registry for each Aide hired.	01/07/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEKALB MEMORIAL HOSPITAL HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 ERIE PASS AUBURN, IN 46706
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE