

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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 visit was a home health agency federal recertification survey. This was a partial extended survey.</p> <p>Survey dates: January 7, 8, and 9, 2013</p> <p>Facility: 005296</p> <p>Medicaid Vendor: 100263530A</p> <p>Surveyor: Susan E. Sparks, RN, Lead PH Nurse Surveyor Bridget Boston, PH Nurse Surveyor Marty Coons, PH Nurse Surveyor</p> <p>Facility census: Skilled patients 555 Home Health Aide Patients 14 Personal Service Only Patients 31 Total 600</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 11, 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: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140		
(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>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on observation, interview, and review of agency policies, the agency failed to ensure it had provided services in accordance with its own infection control policies and procedures in 1 of 2 home health aide home visit observations (4) and 1 of 3 registered nurse home visit observations of wound care (3) creating the potential for the spread of disease causing organisms among staff and the agency's 68 current patients.</p>	G0121	<p>Administrator reviewed the infection control policy with the nursing, therapy and aide staff, including handwashing, double-bag technique and prevention of cross-contamination. All staff will receive annual competencies to ensure compliance with the current infection control policy, including random supervised visits to evaluate adherence to infection control policies/procedures. The Clinical Supervisor of Home Care will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	01/16/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's 9/14/12 "Hand washing and Hand Hygiene Procedure" policy number 8035 states, "Alcohol hand sanitizing gel of foam may be used in the absence of body fluids contamination of hands. Hands will be washed as follows: ... Personnel providing care/service in the home setting will wash their hands: . . . before and after each contact with a patient/client . . . Before and after gloves are used." 2. On 1/8/13 at 1:15 PM, employee C was observed providing wound care to a patient with a Stage II decubitus ulcer on left outer heel of patient #3. Employee C, after sanitizing hands, donned clean gloves, placed a white store plastic bag on the floor up against the patients electric wheelchair, and proceeded to remove the soiled dressing from the bottom of the left heel. Employee C shoved the soiled dressing into the bottom of the plastic bag. Employee C then removed soiled gloves, tossing the soiled gloves onto the plastic bag causing the plastic bag to crumble and allowing the soiled dressings from the plastic bag to fall directly up against the electric wheelchair causing contamination the area. Employee C then, after sanitizing hands and donning clean gloves, continued to cleanse the left 			
--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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>heel and applying a new dressing. Employee C removed soiled gloves, tossed them into the white plastic bag on the floor, gathered the white plastic bag and tied it off, and handed it to the patient's family member to be thrown away. Employee C did not cover the soiled white trash bag with another bag or warn the family member of the bag being contaminated nor did employee C attempt to cleanse the wheelchair.</p> <p>3. Home visit number 4 was conducted on 1/8/13 at 7:30 AM, with employee F, a home health aide. The aide was observed to provide a bed bath to patient number 4. The aide completed hand hygiene and donned clean gloves. The aide prepared a large tub of water for the patient's bath, placed three clean washcloths into the water and then washed the patient's face and began bathing the patient. After washing the perineum, the aide turned the patient on his / her side and washed the patient's back with the same washcloth. She then continued to wash the patient's buttocks, which were red and with broken skin. After the bath was completed, the aide cleaned the bath equipment and gathered the dirty linens while still wearing the same gloves. She then shaved the patient with an electric razor, gathered cotton balls and vinegar from the patient's dresser, soaked a cotton ball with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140		
(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>vinegar and applied the vinegar to the patient's face, assisted the patient to don clothing, and then transferred the patient from the bed to a wheelchair via a Hoyer lift. The aide then removed her gloves and completed hand hygiene.</p> <p>On 1/9/13 at 1:00 PM, employee A, a registered nurse, indicated employee F had not followed the agency's infection control policy and procedure.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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			
G0145	<p>484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days.</p> <p>Based on clinical record review and interview, the agency failed to ensure documentation evidenced the 60 day summary had been sent to the physician in 3 of 6 records reviewed of patients receiving care longer then 60 days with the potential to affect all patients receiving services longer than 60 days. (1, 5 and 6).</p> <p>Findings:</p> <p>1. Clinical record # 1, start of care 8/26/11, failed to evidence a 60 day summary report had been sent to the physician for the certification period of 10/19/12 to 12/17/12.</p> <p>2. Clinical record 5, start of care 12/21/10, evidenced the patient received skilled nurse and home health aide services. The record failed to evidence a 60 day summary had been sent to the physician for the certification periods ending 10/10/12 and 12/9/12.</p>	G0145	<p>Administrator inserviced the nursing and therapy staff regarding compliance with the 60-Day Summary report being sent every sixty (60) days with the physician-ordered plan of care as a means of communicating and coordinating with the physician. One hundred percent (100%) of all active clinical records will be audited for a minimum of two (2) months to ensure compliance with the 60-Day Summary plan of correction. Following evidence of compliance with the plan of correction in all active charts, ten percent (10%) of all clinical records will then be audited quarterly at recertification for evidence of compliance with the requirement to send a 60-Day Summary. The QI Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	01/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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>3. Clinical record 6, start of care 5/20/11, evidenced the patient received skilled nurse and home health aide services. The record failed to evidence a 60 day summary had been sent to the physician for the certification periods ending 9/10/12 and 11/9/12.</p> <p>4. On 1/8/13 at 3:45 PM, employee E indicated the sixty (60) day summaries were mailed separately from the plans of care and the agency did not have evidence of the mailings.</p> <p>5. The policy titled "Physician Written Reports" dated 5/23/12 stated, "Written report will serve as a means of communicating to and coordinating with the physician regarding patient care and treatment. Written physician reports will be completed as indicated by client condition and / or regulatory requirements."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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			
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 orders were present to admit the patient to home care services and continue home care services and visits were made as identified on the plan of care for 11 of 12 clinical records reviewed creating the potential for treatment omission and patient harm affecting all 68 patients of the agency. (# 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, and 12)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 8/26/11, included a comprehensive assessment dated 12/14/12 and a plan of care dated 12/18/12 through 2/15/12. The record failed to evidence a physician order to continue the patient for home care services.</p> <p>On 1/9/13 at 1:00 PM, employee A indicated the physician had not been called for a verbal order for the orders on the plan of care.</p> <p>2. Clinical record 2, SOC 11/20/12,</p>	G0158	<p>The Administrator reviewed with the nurses, therapists and aides the requirement to ensure that orders are present to admit the patient to home care services and continue home care services, and that visits are made as identified by the patient's plan of care. One hundred percent (100%) of all active clinical records will be audited for a minimum of two (2) months to ensure compliance with the requirement that orders are present to admit or continue home care services and that visits are performed per the physician-ordered plan of care. Following evidence of compliance with the plan of correction in all active charts, ten percent (10%) of all clinical records will then be audited quarterly for evidence of continued compliance with the plan of correction. The QI Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	01/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140		
(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>included a comprehensive assessment dated 11/20/12 and a plan of care dated 11/20/12-1/18/13. The record failed to evidence a physician order to admit the patient for home care services.</p> <p>On 1/9/13 at 1:32 PM, employee A indicated the plan of care was the verbal order.</p> <p>3. Clinical record 3, SOC 6/16/12, included a comprehensive assessment dated 10/11/12 and a plan of care dated 10/14/12 through 12/12/12. The record failed to evidence a physician order to continue the patient for home care services.</p> <p>On 1/9/12 at 1 PM, employee A indicated the plan of care was the verbal order.</p> <p>4. Clinical record 4, SOC 12/9/12, included a comprehensive assessment dated 12/9/12 and a plan of care dated 12/9/12 through 2/6/13. The record failed to evidence a physician order to admit the patient for home care services.</p> <p>On 1/9/13 at 2:40 PM, employee A indicated the plan of care was the verbal order.</p> <p>The patient assessment dated 12/9/12</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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>evidenced the patient was admitted with a 8 inch abdominal surgical incision, a "healing" surgical incision on the left buttock, a colostomy, and a urinary catheter. The record evidenced skilled nurse visits were completed on 12/12/12, 12/13/12, 12/19/12, 12/22/12, 12/28/12, and 1/3/13. The record failed to evidence orders for these visits.</p> <p>On 1/8/13 at 2:25 PM, employee A indicated the record did not include an order for the nurse visits provided.</p> <p>5. Clinical record 5, SOC 12/21/10, included a comprehensive assessment dated 12/8/12 and a plan of care dated 12/10/12 to 2/7/13. The record failed to evidence a physician order to continue the patient for home care services.</p> <p>On 1/9/13 at 2:52 PM, employee A indicated the plan of care was the verbal order.</p> <p>6. Clinical record 6, SOC 5/2/11, included a comprehensive assessment dated 11/7/12 and a plan of care dated 11/10/12 through 1/8/13 . The record failed to evidence a physician order to continue the patient for home care services.</p> <p>On 1/9/13 at 2:25 PM , employee</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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>A indicated the plan of care was the verbal order.</p> <p>7. Clinical record 7, SOC 8/24/12, included a comprehensive assessment dated 11/15/12 and a plan of care dated 11/15/12 through 1/13/13. The record failed to evidence a physician order to continue the patient for home care services.</p> <p>On 1/9/13 at 12:30 PM, employee A indicated the plan of care was the verbal order.</p> <p>8. Clinical record 9, SOC 6/1/12, included a plan of care for the certification period of 11/28/12 to 1/26/13 that identified the patient was to receive occupational therapy (OT) services one time a week for one week, then 2 times a week for 6 weeks. The clinical record failed to evidence 2 OT visits week 6.</p> <p>Clinical record 9, SOC 6/1/12, included a comprehensive assessment dated 11/17/12 and a plan of care dated 11/17/12 through 1/26/12. The record failed to evidence a physician order to continue the patient for home care services.</p> <p>On 1/9/13 at 1:12 PM, employee A indicated the plan of care was the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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>verbal order.</p> <p>9. Clinical record 10, SOC 9/26/12, included a comprehensive assessment dated 9/26/12 and a plan of care dated 9/26/12 through 11/24/12. The record failed to evidence a physician order to admit the patient for home care services.</p> <p>On 1/9/13 at 1:23 PM, employee A indicated the plan of care was the verbal order.</p> <p>The plan of care for the certification period of 9/26/12 to 11/26/12 evidenced the patient was to receive skilled nursing two times a week for 3 weeks, then one time a week for 2 weeks. The record failed to evidence a SN visit during week 5.</p> <p>On 1/9/13 at 1:27 employee A indicated the clinical record evidenced a note that stated, "No nursing available will schedule next week." Employee A indicated this was not acceptable.</p> <p>10. Clinical record 11, SOC 11/6/12, included a plan of care for the certification period of 11/6/12 to 1/4/13 that identified the patient was to receive social worker (SW) services one time a week for 1 week. The clinical record failed to evidence a SW visit.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140		
(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>Clinical record 11, SOC 11/6/12, included plans of care dated 11/6/12 and 1/4/13. The record failed to evidence a physician order to admit the patient for home care services and to continue home care services for the second certification period.</p> <p>On 1/9/13 at 1:25 PM, employee A indicated the plan of care was the verbal order.</p> <p>11. Clinical record 12, SOC 9/22/12, included a comprehensive assessment dated 9/22/12 and a plan of care dated 9/22/12 through 11/20/12. The record failed to evidence a physician order to admit the patient for home care services.</p> <p>On 1/9/13 at 12:45 PM, employee A indicated the plan of care was the verbal order.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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			
G0159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on observation, clinical record review, and interview, the agency failed to ensure plans of care included all services the patient received in 2 (# 1 and 2) of 2 records reviewed of patients with home visits where services were being provided by a another agency with the potential to affect all of the agency's patients receiving services from another agency.</p> <p>The findings include:</p> <p>1. During a home visit on 1/7/13 at 1 PM to patient #1, observation identified the patient was receiving personal care services from another agency. The plan of care for the certification period 12/18/12 to 2/15/13 failed to identify the patient was receiving personal care services from another agency.</p>	G0159	The Administrator inserviced the nurses and therapists on the requirement that all services must be reflected on the patient's plan of care, including all services provided by another agency. One hundred percent (100%) of all active clinical records will be audited for a minimum of two (2) months to ensure compliance with the requirement that all services must be reflected on the patient's plan of care. Following evidence of compliance with the plan of correction in all active charts, ten percent (10%) of all clinical records will then be audited quarterly for evidence of continued compliance with reflecting all pertinent services on the patient's plan of care. The QI Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	01/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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. During a home visit on 1/8/13 at 8:10 AM to patient #2, observation identified the patient was receiving personal care services from another agency. The plan of care for the certification period 11/20/12 to 1/18/13 failed to identify the patient was receiving personal care services from another agency.</p> <p>3. The quality improvement manager, employee A, indicated, on 1/8/13 at 2:30 PM, the plans of care in records numbered 1 and 2 did not include all services the patient received.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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			
G0195	<p>484.34 MEDICAL SOCIAL SERVICES If the agency furnishes medical social services, those services are given by a qualified social worker or by a qualified social work assistant under the supervision of a qualified social worker, and in accordance with the plan of care. The social worker assists the physician and other team members in understanding the significant social and emotional factors related to the health problems.</p> <p>Based on clinical record review and interview, the agency failed to ensure the social worker provided care as ordered by the physician in 1 of 2 clinical records reviewed of patients receiving social work services with the potential to affect all patients with orders for social work services. (# 11)</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record 11, start of care 11/6/12, included a plan of care for the certification period of 11/6/12 to 1/4/13 with physician orders for master social worker (SW) one time a week for 1 week. The clinical record failed to evidence a SW visit. On 1/9/13 at 1:25 PM, employee A indicated the SW had talked to the father and not to the patient and had not made another attempt to reach the patient. 	G0195	The Administrator reviewed with the MSW staff that services are provided in accordance with the physician-ordered plan of care. One hundred percent (100%) of all active clinical records with MSW orders will be audited for a minimum of two (2) months to ensure that MSW care is provided in accordance with the physician-ordered plan of care. Following evidence of compliance in all active charts, ten percent (10%) of all clinical records with MSW orders will then be audited quarterly to ensure continued compliance with the plan of correction. The Clinical Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	01/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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			
G0229	<p>484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days for 3 of 3 records reviewed (# 3, 4, 9) of patients receiving skilled services and home health aide services longer then 14 days with the potential to affect all</p>	G0229	<p>The Administrator inserviced the nursing and therapy staff on the aide supervision standard and the requirement that an onsite visit must be performed in the patient's home no less frequently than every two (2) weeks. One hundred percent (100%) of all active clinical records will be audited for a minimum of two (2) months for evidence that aide supervisory visits are conducted onsite no less frequently than every two (2) weeks. Following evidence of compliance in all active clinical records, ten percent (10%) of all clinical records will then be audited quarterly to ensure continued compliance with the aide supervision plan of correction. The Clinical Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	01/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140		
(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>patients of the agency that receive skilled and home health aide services longer than 14 days.</p> <p>Findings include:</p> <p>1. Clinical record # 3, start of care (SOC) 6/16/12, included a plan of care for the certification period 10/14/12 through 12/12/12 with orders for skilled nursing and home health aide services. The record failed to evidence documentation of supervisory visits from 11/9/12 to 11/26/12, a period of 18 days, and 11/25 12 to 12/12/12, a period of 16 days.</p> <p>On 1/9/13 at 1:05 PM, employee A indicated the record did not evidence supervisory visits as required.</p> <p>2. Clinical Record # 4, SOC 12/9/12, included a plan of care for the certification period 12/9/12 through 2/6/13 with orders for skilled and home health aide services. The record failed to evidence any supervisory visits had been completed. The record evidenced aide services were provided on December 13, 18, and 27, 2012, and January 1 and 3, 2013.</p> <p>On 1/8/13 at 2:12 PM, employee A indicated the record did not evidence a supervisory visit.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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>3. Clinical record # 9, SOC 6/1/12, included a plan of care for the certification period 11/28/12 through 1/26/13 with orders for skilled nursing and home health aide services. The record failed to evidence documentation of supervisory visits from 11/28/12 to 1/2/13, a period of 36 days.</p> <p>On 1/9/13 at 1:25 PM, employee A indicated the record did not evidence supervisory visits as required.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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			
G0236	<p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure clinical notes were written/or signed on the day service was rendered for 1 (# 1) of 12 records reviewed creating the potential to affect all 68 patients of the agency.</p> <p>Findings include:</p> <p>1. The policy provided for review titled "Documentation Timeliness and Authenticity", policy # "1440", effective date "3/3/11" and a revised date of "1/17/11" states, "Establish expectation for timely completion of clinical documentation and entries into patient/client's clinical records. Identify process to authenticate entries into patient/client's clinical record. Patient /Client electronic/non-electronic chart entries may be completed by the home</p>	G0236	The Administrator reviewed the documentation policy with the clinical staff and reviewed the agency expectation of point of care documentation. One hundred percent (100%) of all active clinical records will be audited for a minimum of two (2) months to ensure compliance with the agency documentation policy. Following evidence of compliance in all active clinical records, ten percent (10%) of all patient records will then be audited quarterly for evidence that the clinical staff are compliant in completing documentation per agency policy. The Clinical Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	01/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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>health care interdisciplinary team including, but not limited to administration, medical nursing, therapists, social services, aides, and other health providers. Electronic Documentation: The electronic record will be opened at the time of the home visit and documentation will be at point of care. The electronic record will be closed at the conclusion of the home visit insuring accurate home visit time in and time out.</p> <p>2. Clinical record #1, start of care 8/26/11, included documentation by the RN, employee D, for services rendered on 12/24/12 and 12/31/12. The RN failed to close the conclusion of the home visit on the day of the point of care. The RN's signature and date for the 12/24/12 visit was not completed until 12/30/12 and the RN's signature and date for the 12/31/12 visit was not completed until 1/17/13.</p> <p>3. On 1/8/13 at 2:40 PM, employee A indicated the nurses notes, date, and signature should have been completed on the day services were rendered and not after the fact.</p> <p>4. On 1/8/13 at 2:45, Employee D indicated completion of services rendered on home visit dates and documented in the medical records were not always</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
	completed the day services were actually rendered. Employee D also indicated until the electronic signature is completed, medical record documentation can be changed and/or updated.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140		
(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	
G0337	<p>484.55(c) DRUG REGIMEN REVIEW</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record review and interview, the agency failed to ensure the comprehensive assessment included a review of all medications the patient was currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy in 5 of 5 records reviewed with a recertification assessment with the potential to affect all patients requiring a recertification assessment. (1, 3, 5, 6, and 9)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 8/25/11, included a recertification assessment for the certification period 12/18/12 through 2/15/13 that failed to evidence the registered nurse completed a review of all medications the patient was currently using in order to identify any</p>	G0337	<p>The Administrator inserviced the clinical staff on the requirement that the recertification assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and non-compliance with drug therapy.No software enhancements were required due to the drug regimen review being a supporting feature available to staff during the recertification assessment. When following up with Employee A, they reported: "I was referencing the M2000 Oasis question to the recert assessment. I must have misunderstood the question that was asked at the time of the survey. The software does have the drug regimen review included in the assessment." In order to verify the presence of the drug regimen review in the recertification assessment, please see the supporting documentation (attached).One</p>	01/16/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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>potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>2. Clinical record 3, SOC 6/16/12, included a recertification assessment for the certification period 10/14/12 through 12/12/12 that failed to evidence the registered nurse completed a review of all medications the patient was currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>3. Clinical record 5, SOC 12/21/10, included a recertification assessment for the certification period 12/10/12 through 2/7/13 that failed to evidence the registered nurse completed a review of all medications the patient was currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p>		<p>hundred percent (100%) of all active clinical records will be audited for a minimum of two (2) months for evidence that a review of all medication is completed at recertification. Following evidence of compliance with all active records, ten percent (10%) of all clinical records will then be audited quarterly for evidence of continued compliance with the drug regimen review plan of correction. The QI Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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>4. Clinical record 6, SOC 5/2/11, included a recertification assessment for the certification period 11/10/12 through 1/8/13 that failed to evidence the registered nurse completed a review of all medications the patient was currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>5. Clinical record 9, SOC 6/1/12, included a recertification assessment for the certification period 11/28/12 through 1/26/13 that failed to evidence the registered nurse completed a review of all medications the patient was currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>6. On 1/9/13 at 1:30 PM, employee A indicated the software does not have that feature to prompt the SN in the field.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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			
G0339	<p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.</p> <p>Based on clinical record review and interview, the agency failed to ensure comprehensive assessments had been revised and updated the last five (5) days of every 60 days in 1 (# 1) of 5 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's patients receiving services for longer than 60 days.</p> <p>The findings include:</p> <p>1. Clinical record # 1, start of care (SOC) 08/26/11, revealed a recertification comprehensive assessment had been completed for the certification period ending 12/18/12. The assessment had a M 0090 date of 12/14/12, but the registered nurse signature date for completion was 12/19/12. This would have been day 61 and not during the last 5 days of the certification period.</p>	G0339	<p>Administrator instructed nursing and therapy staff regarding compliance with the comprehensive assessment that must be updated and revised the last five (5) days of every sixty (60) days beginning with the start of care date. One hundred percent (100%) of all active clinical records requiring recertification assessments will be audited for a minimum of two (2) months for evidence of compliance with the requirement to update the comprehensive assessment within the five (5) days allotted. Following evidence of compliance in all active clinical records, ten percent (10%) of all clinical records will then be audited quarterly at recertification for evidence of continued compliance with the plan of correction. The QI Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	01/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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 1/8/13 at 1:50 PM, employee A indicated employee D failed to complete the comprehensive assessment within the 56-60 day time frame and that the M 0090 date and signature date need to be one and the same.</p> <p>3. On 1/8/13 at 2:45 PM, employee D, indicated that completion of services rendered on home visit dates was documented in the medical record on the date the nurse closed the visit and were not always the day services were actually rendered. Employee D also indicated until the electronic signature is completed, medical record documentation can be changed and/or updated.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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			
G0341	<p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Based on clinical record review and interview, the agency failed to ensure the registered nurse completed a transfer assessment within 48 of hours of when the patient was transferred to the hospital for 1 of 1 record reviewed of a patient transferred to the hospital with the potential to affect all patients who are transferred. (7)</p> <p>Findings:</p> <ol style="list-style-type: none"> Clinical record 7, start of care 11/15/12, identified the patient had a skilled nurse (SN) on 12/7/12 and the nurse was knowledgeable the patient was having surgery the next week. The SN completed the transfer 12/19/12 indicating the patient was transferred to the hospital on 12/15/12, more than 48 hours later. On 1/9/13 at 12:30 PM, employee A indicated the SN has 48 hours to do a transfer when a patient transfer and 6 days later is not within the guidelines. 	G0341	<p>Administrator instructed the nursing and therapy staff regarding compliance with the transfer assessment that must be performed within forty-eight (48) hours of when the patient was transferred. One hundred percent (100%) of all active clinical records will be audited for a minimum of two (2) months for evidence of compliance with the requirement that all transfers must be performed within forty-eight (48) hours of when the patient was transferred. Following evidence of compliance all active clinical records, ten percent (10%) of all clinical records will then be audited quarterly for evidence of continued compliance with the plan of correction. The QI Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	01/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140		
(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 visit was a home health agency state licensure survey.</p> <p>Survey dates: January 7, 8, and 9, 2013</p> <p>Facility: 005296</p> <p>Medicaid Vendor: 100263530A</p> <p>Surveyor: Susan E. Sparks, RN, Lead PH Nurse Surveyor Bridget Boston, PH Nurse Surveyor Marty Coons, PH Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 11, 2013</p>	N0000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, interview, and review of agency policies, the agency failed to ensure it had provided services in accordance with its own infection control policies and procedures in 1 of 2 home health aide home visit observations (4) and 1 of 3 registered nurse home visit observations of wound care (3) creating the potential for the spread of disease causing organisms among staff and the agency's 68 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The agency's 9/14/12 "Hand washing and Hand Hygiene Procedure" policy number 8035 states, "Alcohol hand sanitizing gel of foam may be used in the absence of body fluids contamination of hands. Hands will be washed as follows: ... Personnel providing care/service in the home setting will wash their hands: . . . before and after each contact with a patient/client . . . Before and after gloves are used." On 1/8/13 at 1:15 PM, employee C 	N0470	<p>Administrator reviewed the infection control policy with the nursing, therapy and aide staff, including handwashing, double-bag technique and prevention of cross-contamination. All staff will receive annual competencies to ensure compliance with the current infection control policy, including random supervised visits to evaluate adherence to infection control policies/procedures. The Clinical Supervisor of Home Care will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	01/16/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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>was observed providing wound care to a patient with a Stage II decubitus ulcer on left outer heel of patient #3. Employee C, after sanitizing hands, donned clean gloves, placed a white store plastic bag on the floor up against the patients electric wheelchair, and proceeded to remove the soiled dressing from the bottom of the left heel. Employee C shoved the soiled dressing into the bottom of the plastic bag. Employee C then removed soiled gloves, tossing the soiled gloves onto the plastic bag causing the plastic bag to crumble and allowing the soiled dressings from the plastic bag to fall directly up against the electric wheelchair causing contamination the area. Employee C then, after sanitizing hands and donning clean gloves, continued to cleanse the left heel and applying a new dressing. Employee C removed soiled gloves, tossed them into the white plastic bag on the floor, gathered the white plastic bag and tied it off, and handed it to the patient's family member to be thrown away. Employee C did not cover the soiled white trash bag with another bag or warn the family member of the bag being contaminated nor did employee C attempt to cleanse the wheelchair.</p> <p>3. Home visit number 4 was conducted on 1/8/13 at 7:30 AM, with employee F, a home health aide. The aide was observed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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>to provide a bed bath to patient number 4. The aide completed hand hygiene and donned clean gloves. The aide prepared a large tub of water for the patient's bath, placed three clean washcloths into the water and then washed the patient's face and began bathing the patient. After washing the perineum, the aide turned the patient on his / her side and washed the patient's back with the same washcloth. She then continued to wash the patient's buttocks, which were red and with broken skin. After the bath was completed, the aide cleaned the bath equipment and gathered the dirty linens while still wearing the same gloves. She then shaved the patient with an electric razor, gathered cotton balls and vinegar from the patient's dresser, soaked a cotton ball with vinegar and applied the vinegar to the patient's face, assisted the patient to don clothing, and then transferred the patient from the bed to a wheelchair via a Hoyer lift. The aide then removed her gloves and completed hand hygiene.</p> <p>On 1/9/13 at 1:00 PM, employee A, a registered nurse, indicated employee F had not followed the agency's infection control policy and procedure.</p>			
--	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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			
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: Based on clinical record review and interview, the agency failed to ensure orders were present to admit the patient to home care services and continue home care services and visits were made as identified on the plan of care for 11 of 12 clinical records reviewed creating the potential for treatment omission and patient harm affecting all 68 patients of the agency. (# 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, and 12)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 8/26/11, included a comprehensive assessment dated 12/14/12 and a plan of care dated 12/18/12 through 2/15/12. The record failed to evidence a physician order to continue the patient for home care services.</p> <p>On 1/9/13 at 1:00 PM, employee A indicated the physician had not been called for a verbal order for the orders on the plan of care.</p> <p>2. Clinical record 2, SOC 11/20/12,</p>	N0522	<p>The Administrator reviewed with the nurses, therapists and aides the requirement to ensure that orders are present to admit the patient to home care services and continue home care services, and that visits are made as identified by the patient's plan of care. One hundred percent (100%) of all active clinical records will be audited for a minimum of two (2) months to ensure compliance with the requirement that orders are present to admit or continue home care services and that visits are performed per the physician-ordered plan of care. Following evidence of compliance with the plan of correction in all active charts, ten percent (10%) of all clinical records will then be audited quarterly for evidence of continued compliance with the plan of correction. The QI Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	01/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140		
(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>included a comprehensive assessment dated 11/20/12 and a plan of care dated 11/20/12-1/18/13. The record failed to evidence a physician order to admit the patient for home care services.</p> <p>On 1/9/13 at 1:32 PM, employee A indicated the plan of care was the verbal order.</p> <p>3. Clinical record 3, SOC 6/16/12, included a comprehensive assessment dated 10/11/12 and a plan of care dated 10/14/12 through 12/12/12. The record failed to evidence a physician order to continue the patient for home care services.</p> <p>On 1/9/12 at 1 PM, employee A indicated the plan of care was the verbal order.</p> <p>4. Clinical record 4, SOC 12/9/12, included a comprehensive assessment dated 12/9/12 and a plan of care dated 12/9/12 through 2/6/13. The record failed to evidence a physician order to admit the patient for home care services.</p> <p>On 1/9/13 at 2:40 PM, employee A indicated the plan of care was the verbal order.</p> <p>The patient assessment dated 12/9/12</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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>evidenced the patient was admitted with a 8 inch abdominal surgical incision, a "healing" surgical incision on the left buttock, a colostomy, and a urinary catheter. The record evidenced skilled nurse visits were completed on 12/12/12, 12/13/12, 12/19/12, 12/22/12, 12/28/12, and 1/3/13. The record failed to evidence orders for these visits.</p> <p>On 1/8/13 at 2:25 PM, employee A indicated the record did not include an order for the nurse visits provided.</p> <p>5. Clinical record 5, SOC 12/21/10, included a comprehensive assessment dated 12/8/12 and a plan of care dated 12/10/12 to 2/7/13. The record failed to evidence a physician order to continue the patient for home care services.</p> <p>On 1/9/13 at 2:52 PM, employee A indicated the plan of care was the verbal order.</p> <p>6. Clinical record 6, SOC 5/2/11, included a comprehensive assessment dated 11/7/12 and a plan of care dated 11/10/12 through 1/8/13 . The record failed to evidence a physician order to continue the patient for home care services.</p> <p>On 1/9/13 at 2:25 PM , employee</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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>A indicated the plan of care was the verbal order.</p> <p>7. Clinical record 7, SOC 8/24/12, included a comprehensive assessment dated 11/15/12 and a plan of care dated 11/15/12 through 1/13/13. The record failed to evidence a physician order to continue the patient for home care services.</p> <p>On 1/9/13 at 12:30 PM, employee A indicated the plan of care was the verbal order.</p> <p>8. Clinical record 9, SOC 6/1/12, included a plan of care for the certification period of 11/28/12 to 1/26/13 that identified the patient was to receive occupational therapy (OT) services one time a week for one week, then 2 times a week for 6 weeks. The clinical record failed to evidence 2 OT visits week 6.</p> <p>Clinical record 9, SOC 6/1/12, included a comprehensive assessment dated 11/17/12 and a plan of care dated 11/17/12 through 1/26/12. The record failed to evidence a physician order to continue the patient for home care services.</p> <p>On 1/9/13 at 1:12 PM, employee A indicated the plan of care was the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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>verbal order.</p> <p>9. Clinical record 10, SOC 9/26/12, included a comprehensive assessment dated 9/26/12 and a plan of care dated 9/26/12 through 11/24/12. The record failed to evidence a physician order to admit the patient for home care services.</p> <p>On 1/9/13 at 1:23 PM, employee A indicated the plan of care was the verbal order.</p> <p>The plan of care for the certification period of 9/26/12 to 11/26/12 evidenced the patient was to receive skilled nursing two times a week for 3 weeks, then one time a week for 2 weeks. The record failed to evidence a SN visit during week 5.</p> <p>On 1/9/13 at 1:27 employee A indicated the clinical record evidenced a note that stated, "No nursing available will schedule next week." Employee A indicated this was not acceptable.</p> <p>10. Clinical record 11, SOC 11/6/12, included a plan of care for the certification period of 11/6/12 to 1/4/13 that identified the patient was to receive social worker (SW) services one time a week for 1 week. The clinical record failed to evidence a SW visit.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140		
(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>Clinical record 11, SOC 11/6/12, included plans of care dated 11/6/12 and 1/4/13. The record failed to evidence a physician order to admit the patient for home care services and to continue home care services for the second certification period.</p> <p>On 1/9/13 at 1:25 PM, employee A indicated the plan of care was the verbal order.</p> <p>11. Clinical record 12, SOC 9/22/12, included a comprehensive assessment dated 9/22/12 and a plan of care dated 9/22/12 through 11/20/12. The record failed to evidence a physician order to admit the patient for home care services.</p> <p>On 1/9/13 at 12:45 PM, employee A indicated the plan of care was the verbal order.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

N0524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on observation, clinical record review, and interview, the agency failed to ensure plans of care included all services the patient received in 2 (# 1 and 2) of 2 records reviewed of patients with home visits where services were being provided by a another agency with the potential to affect all of the agency's patients receiving services from another agency.</p> <p>The findings include:</p>	N0524	The Administrator inserviced the nurses and therapists on the requirement that all services must be reflected on the patient's plan of care, including all services provided by another agency. One hundred percent (100%) of all active clinical records will be audited for a minimum of two (2) months to ensure compliance with the requirement that all services must be reflected on the patient's plan of care. Following evidence of compliance with the plan of correction in all active	01/16/2013
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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. During a home visit on 1/7/13 at 1 PM to patient #1, observation identified the patient was receiving personal care services from another agency. The plan of care for the certification period 12/18/12 to 2/15/13 failed to identify the patient was receiving personal care services from another agency.</p> <p>2. During a home visit on 1/8/13 at 8:10 AM to patient #2, observation identified the patient was receiving personal care services from another agency. The plan of care for the certification period 11/20/12 to 1/18/13 failed to identify the patient was receiving personal care services from another agency.</p> <p>3. The quality improvement manager, employee A, indicated, on 1/8/13 at 2:30 PM, the plans of care in records numbered 1 and 2 did not include all services the patient received.</p>		charts, ten percent (10%) of all clinical records will then be audited quarterly for evidence of continued compliance with reflecting all pertinent services on the patient's plan of care. The QI Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE			STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140		
(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	
N0529	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months.</p> <p>Based on clinical record review and interview, the agency failed to ensure documentation evidenced the 60 day summary had been sent to the physician in 3 of 6 records reviewed of patients receiving care longer then 60 days with the potential to affect all patients receiving services longer than 60 days. (1, 5 and 6).</p> <p>Findings:</p> <p>1. Clinical record # 1, start of care 8/26/11, failed to evidence a 60 day summary report had been sent to the physician for the certification period of 10/19/12 to 12/17/12.</p> <p>2. Clinical record 5, start of care 12/21/10, evidenced the patient received skilled nurse and home health aide</p>	N0529	<p>Administrator inserviced the nursing and therapy staff regarding compliance with the 60-Day Summary report being sent every sixty (60) days with the physician-ordered plan of care as a means of communicating and coordinating with the physician. One hundred percent (100%) of all active clinical records will be audited for a minimum of two (2) months to ensure compliance with the 60-Day plan of correction. Following evidence of compliance with the plan of correction in all active charts, ten percent (10%) of all clinical records will then be audited quarterly at recertification for evidence of continued compliance with the requirement to send a 60-Day Summary. The QI Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	01/16/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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>services. The record failed to evidence a 60 day summary had been sent to the physician for the certification periods ending 10/10/12 and 12/9/12.</p> <p>3. Clinical record 6, start of care 5/20/11, evidenced the patient received skilled nurse and home health aide services. The record failed to evidence a 60 day summary had been sent to the physician for the certification periods ending 9/10/12 and 11/9/12.</p> <p>4. On 1/8/13 at 3:45 PM, employee E indicated the sixty (60) day summaries were mailed separately from the plans of care and the agency did not have evidence of the mailings.</p> <p>5. The policy titled "Physician Written Reports" dated 5/23/12 stated, "Written report will serve as a means of communicating to and coordinating with the physician regarding patient care and treatment. Written physician reports will be completed as indicated by client condition and / or regulatory requirements."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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			
N0572	<p>410 IAC 17-14-1(e) Scope of Services Rule 14 Sec. 1(e) Any social services furnished by the home health agency, shall be provided by a social worker, or a social work assistant under the supervision of a social worker, and in accordance with the medical plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure the social worker provided care as ordered by the physician in 1 of 2 clinical records reviewed of patients receiving social work services with the potential to affect all patients with orders for social work services. (# 11)</p> <p>Findings:</p> <p>1. Clinical record 11, start of care 11/6/12, included a plan of care for the certification period of 11/6/12 to 1/4/13 with physician orders for master social worker (SW) one time a week for 1 week. The clinical record failed to evidence a SW visit.</p> <p>2. On 1/9/13 at 1:25 PM, employee A indicated the SW had talked to the father and not to the patient and had not made another attempt to reach the patient.</p>	N0572	<p>The Administrator reviewed with the MSW staff that services are provided in accordance with the physician-ordered plan of care. One hundred percent (100%) of all active clinical records with MSW orders will be audited for a minimum of two (2) months to ensure that MSW care is provided in accordance with the physician-ordered plan of care. Following evidence of compliance in all active charts, ten percent (10%) of all clinical records with MSW orders will then be audited quarterly to ensure continued compliance with the plan of correction. The Clinical Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	01/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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			
N0608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure clinical notes were written/or signed on the day service was rendered for 1 (# 1) of 12 records reviewed creating the potential to affect all 68 patients of the agency.</p> <p>Findings include:</p> <p>1. The policy provided for review titled "Documentation Timeliness and Authenticity", policy # "1440", effective date "3/3/11" and a revised date of "1/17/11" states, "Establish expectation for timely completion of clinical</p>	N0608	The Administrator reviewed the documentation policy with the clinical staff and reviewed the agency expectation of point of care documentation. One hundred percent (100%) of all active clinical records will be audited for a minimum of two (2) months to ensure compliance with the agency documentation policy. Following evidence of compliance in all active clinical records, ten percent (10%) of all patient records will then be audited quarterly for evidence that the clinical staff are compliant in completing documentation per agency policy. The Clinical Supervisor will be responsible for monitoring these corrective	01/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/09/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140			
(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>documentation and entries into patient/client's clinical records. Identify process to authenticate entries into patient/client's clinical record. Patient /Client electronic/non-electronic chart entries may be completed by the home health care interdisciplinary team including, but not limited to administration, medical nursing, therapists, social services, aides, and other health providers. Electronic Documentation: The electronic record will be opened at the time of the home visit and documentation will be at point of care. The electronic record will be closed at the conclusion of the home visit insuring accurate home visit time in and time out.</p> <p>2. Clinical record #1, start of care 8/26/11, included documentation by the RN, employee D, for services rendered on 12/24/12 and 12/31/12. The RN failed to close the conclusion of the home visit on the day of the point of care. The RN's signature and date for the 12/24/12 visit was not completed until 12/30/12 and the RN's signature and date for the 12/31/12 visit was not completed until 1/17/13.</p> <p>3. On 1/8/13 at 2:40 PM, employee A indicated the nurses notes, date, and signature should have been completed on the day services were rendered and not</p>		actions to ensure that this deficiency is corrected and will not recur.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER HANCOCK REGIONAL HOME HEALTH CARE & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1560 B STATE ST GREENFIELD, IN 46140
---------------------------------------------------------------------------------	----------------------------------------------------------------------------------

(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>after the fact.</p> <p>4. On 1/8/13 at 2:45, Employee D indicated completion of services rendered on home visit dates and documented in the medical records were not always completed the day services were actually rendered. Employee D also indicated until the electronic signature is completed, medical record documentation can be changed and/or updated.</p>			