

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157090	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/11/2013
NAME OF PROVIDER OR SUPPLIER  HERITAGE HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 801 PLAZA DR STE A MARTINSVILLE, IN 46151		
(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	
G000000	<p>This was a federal home health complaint investigation.</p> <p>Complaint # IN 00124961 - Unsubstantiated: Lack of sufficient evidence. Unrelated deficiencies are cited.</p> <p>Survey Date: March 7-8 and 11, 2013</p> <p>Facility #: 005294</p> <p>Medicaid Vendor #: 100263560A</p> <p>Surveyor: Marty Coons, RN, PHNS</p> <p>Heritage Home Health Services is in compliance with 42 CFR 484.14 (d) as related to this complaint.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 15, 2013</p>	G000000			

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:  157090		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/11/2013	
NAME OF PROVIDER OR SUPPLIER  HERITAGE HOME HEALTH SERVICES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 801 PLAZA DR STE A MARTINSVILLE, IN 46151			
(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			
G000121	<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. Based on observation, agency policy review, and job description review, the agency failed to ensure the home health agency's own infection control policies and procedures were followed during 1 of 1 (# 5) home visit observations of patients requiring wound care creating the potential to affect all the patients of the home health agency receiving wound care from employee C.</p> <p>The findings include:</p> <p>1. The agency's undated "Infection Prevention/Control" policy states, "Agency will observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC). ... 2. Hands are washed ... immediately after gloves are removed ... to prevent transfer of microorganisms between other patients or the environment. ... 6. Equipment used for patient care is properly cleaned."</p> <p>2. The agency's undated "Handwashing /Hand Hygiene" policy states, "2. Indications for hand washing and hand</p>	G000121	G 121 - The Supervising Nurse will inservice all direct care staff on infection Prevention /Control Policy and Handwashing/Hand Hygiene and all direct care staff will give a return demonstration of the handwashing technique and Infection Prevention/Control to ensure the agency provides services in accordance with Agency Policy.The Administrator will review Job Descriptions with all Nursing Staff. The Nursing Staff will sign an acknowledgement of their understanding.The Supervising Nurse will perform random on-site co-visits with staff to monitor Handwashing/Hand Hygiene and Infection Prevention/Control during the provision of care. Any issues identified will be immediately addressed.The Administrator will be responsible to make sure all nursing staff understands their Job Descriptions.The Supervising Nurse will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	04/10/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157090		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/11/2013	
NAME OF PROVIDER OR SUPPLIER  HERITAGE HOME HEALTH SERVICES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 801 PLAZA DR STE A MARTINSVILLE, IN 46151			
(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>antiseptis: a. Before performing invasive procedures. d. Between tasks on the same patient. ... e. Before touching a wound. f. After removing gloves. g. After touching objects that are potentially contaminated. ... 1. When decontaminating hands with an alcohol based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers until hands are dry."</p> <p>3. The agency's job description for the staff registered nurse document states, "A. Job Knowledge and Role Responsibilities: ... 9. Implements infection control measure and uses Universal Precautions in the patient's home. ... 15. Uses equipment and supplies efficiently and effectively."</p> <p>4. A home visit was made to patient # 5 with employee C, a registered nurse (RN), on 3-8-13 at 3:15 PM. The RN was observed to provide wound care and dressing changes for both feet for open wounds.</p> <p>A. Observation of the right (R) foot wound care:</p> <p>Upon entering into the patient's room, the RN placed a bag of supplies directly on the seat of a chair without first placing a barrier. She then placed a barrier on the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157090	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOME HEALTH SERVICES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 801 PLAZA DR STE A MARTINSVILLE, IN 46151
---	---

(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>arm of the chair and placed her computer on top. The RN retrieved from the bag the equipment needed to proceed with the nursing assessment, including equipment to take blood pressure, temperature, pulse, respirations, and listen to the patient's lungs. The RN then placed the equipment back into her bag without cleansing it. The RN assisted the patient from the couch into a wheelchair. The patient's lower extremities were red and swollen. The RN left the room to retrieve a large bathroom towel. laying it on the floor in front of the wheelchair, allowing the patient to place both feet upon the bath towel. The RN then applied gloves and began to remove the patient's shoes from both feet and placing the shoes along side the wheelchair. The RN then began removing the blue socks and soiled dressing from the R foot and began touching the R foot and examining the foot while wearing the same gloves. After R foot exam, the RN removed gloves, sanitized hands, reached into her bag, and donned a clean pair of gloves. The RN, with gloved hands, then reached into a medium sized cardboard open box and removed the supplies to perform wound care. The supplies included 1 - 2 x 3 open package of gauze, 2 packages of roll kling gauze, 1 jar of white cream, 1 bottle of normal saline (NS), 1 pair of bandage scissors, 1 package of betadine</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157090		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/11/2013	
NAME OF PROVIDER OR SUPPLIER  HERITAGE HOME HEALTH SERVICES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 801 PLAZA DR STE A MARTINSVILLE, IN 46151			
(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			
	swabs, 1 package of cotton balls, 1 package of non-stick telfa pads, and 1 package of alginate. The RN placed these supplies on a visibly soiled cloth chair cushion that was ripped and torn without placing any type of barrier in between. The RN, without changing gloves, picked up a wad of gauze and poured the NS onto the gauze and began cleansing the R foot. Without changing gloves or sanitizing hands, the RN picked up more gauze, placed this gauze on the rim of the NS, turned the bottle upside down saturating the gauze, and continued to cleanse the R foot. While cleansing the R foot, the RN questioned the patient as to what the patient's blood sugar was this day. After the patient provided the RN with the results of 117, the RN removed her gloves, sanitized her hands, and placed the blood sugar results into the computer. Without sanitizing her hands, the RN donned gloves, retrieved a measurement tool from the open cardboard box, measured the open area on the R foot great toe, then placed the measurement tool back into the box. The RN then, without sanitizing or changing gloves retrieved cotton balls and started to dip the cotton balls into the jar of cream when the patient indicated the other nurse used something else first. The RN indicated she did not see that in the orders but would look into computer to make						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157090	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOME HEALTH SERVICES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 801 PLAZA DR STE A MARTINSVILLE, IN 46151
---	---

(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>sure. The RN touched the computer, checked the orders, and without ever changing gloves or dropping the cotton ball proceeded with dipping the cotton ball into the jar of cream and placed the cream on the patient's R foot. The RN picked up another cotton ball without changing her gloves and dipped the second cotton ball into the same jar as the first and placed the cream on the patient's R foot. The RN then picked up the Alginate package, opened the package with the scissors from the soiled cloth chair cushion, touched the computer to check the orders again, and began to cut a small piece off and place this piece on top of the R great toe along with a telfa pad. The RN then picked up the roll gauze, opened the package and started wrapping roll gauze around the R foot, then picked up the roll of tape, tore a piece off, and secured the end of the gauze kling, all without changing gloves or sanitizing hands.</p> <p>B. Observation of the left (L) foot wound care:</p> <p>The RN sanitized hands, retrieved a large amount of gloves from the RN's supply bag, and placed these gloves on the arm of the large cloth soiled chair without any kind of barrier. The RN then donned a pair of these gloves and began removing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157090	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOME HEALTH SERVICES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 801 PLAZA DR STE A MARTINSVILLE, IN 46151
---	---

(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 blue sock and soiled dressing from the patient's L foot, examined the foot, and verbally encouraged the patient to continue wearing the soft boots at night. The RN removed gloves, sanitized hands, donned clean gloves, retrieved gauze pouring NS over gauze, and began cleansing L foot by wiping up and down from ankle to toes. She repeated this all around L foot. The RN then retrieved the wound measurement tool from the cardboard box along with an ink pen, removed the glove from the R hand and began measuring the wounds around the L foot and writing these measurements on the glove of the L hand. Without sanitizing hands or removing L hand glove with the measurements on it, the RN began placing the measurements into the computer with the R hand. The RN changed gloves without sanitizing hands, retrieved gauze and dipped gauze into the jar of white cream, replaced the jar lid, and began placing the cream on the L foot. Without changing gloves, the RN picked up the scissors from the soiled cloth chair cushion, never cleansing scissors, and started cutting small pieces of alginate and placing them on the L foot wounds along with a telfa pad. The RN then changed gloves, failed to sanitize hands, picked up a package of roll kling gauze, dropped the package on the floor, retrieved the package, and wrapped the L</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157090	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/11/2013
NAME OF PROVIDER OR SUPPLIER  HERITAGE HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 801 PLAZA DR STE A MARTINSVILLE, IN 46151		
(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	
	foot.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157090		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/11/2013	
NAME OF PROVIDER OR SUPPLIER  HERITAGE HOME HEALTH SERVICES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 801 PLAZA DR STE A MARTINSVILLE, IN 46151			
(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			
G000158	<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 policy review, the agency failed to ensure orders on the plan of care were followed by the skilled nurse (SN) to evaluated oxygen (O2) saturations (O2 sats) for 1 of 2 (# 1) records reviewed of patients on oxygen therapy and occupational therapy (OT) services were provided for 1 of 3 (# 5) records reviewed of patients needing OT creating the potential to affect all of the agency's patients receiving O2 or with an order for occupational therapy.</p> <p>The findings include:</p> <p>1. Clinical record # 1 included a plan of care (POC) for the certification period 1-3-13 to 3-3-13 with an order for O2 at 5 liters per nasal cannula and for the</p>	G000158	G 158 The Supervising Nurse will Inservice the Nursing Staff on policy Skilled Nursing Services and the Nursing and Therapy Staff on Patient Admission Process. A pre and post test will be given to ensure learning needs have been met.10% of all clinical records will be audited quarterly. For evidence that nursing is demonstrating competency in providing procedures and documenting and implementing physician orders; and to ensure that therapy staff assessments were completed within forty-eight hours of referral. If therapy was not indicated then an order to notify the physician of the finding was written. Any issue identified will be immediately addressed.The Supervising Nurse will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	04/10/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157090		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/11/2013	
NAME OF PROVIDER OR SUPPLIER  HERITAGE HOME HEALTH SERVICES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 801 PLAZA DR STE A MARTINSVILLE, IN 46151			
(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>skilled nurse to teach about O2 equipment and to assess the effectiveness of the O2 treatment with a goal that the patients O2 sats will remain greater than 90%. Skilled nursing visits on 1-9-13 and 1-11-13 failed to evidence any documentation the O2 sats had been completed.</p> <p>The agency's undated "Skilled Nursing Services" policy states, "Skilled nursing services will be provided .. in accordance with a medical provide Plan of care. ... 4. The nurse will demonstrate competency in providing procedures such as: ... c. Documenting and implementing physician orders."</p> <p>2 Clinical record # 5 included a POC for the certification period 1-4-13 to 3-4-13 with an order for OT to evaluate and treat. The record failed to evidence an OT evaluation or any treatments by an OT. The record also failed to evidence the OT order had been</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157090	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/11/2013
NAME OF PROVIDER OR SUPPLIER  HERITAGE HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 801 PLAZA DR STE A MARTINSVILLE, IN 46151		
(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>discontinued or that the physician had been notified.</p> <p>The agency's undated "Patient Admission Process" policy states, "7. ... assessment will be completed within forty-eight (48) hours of referral."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157090	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOME HEALTH SERVICES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 801 PLAZA DR STE A MARTINSVILLE, IN 46151
---	---

(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
G000170	<p><b>484.30</b> <b>SKILLED NURSING SERVICES</b> The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record and policy review, the agency failed to ensure teh skilled nurse provided care as ordered on the plan of care for 1 of 2 (# 1) records reviewed of patients on oxygen (O2) therapy creating the potential to affect all of the agency's patients receiving O2.</p> <p>Findings include:</p> <p>1. Clinical record # 1 included a plan of care (POC) for the certification period 1-3-13 to 3-3-13 with an order for O2 at 5 liters per nasal cannula and for the skilled nurse to teach about O2 equipment and to assess the effectiveness of the O2 treatment with a goal that the patients O2 sats will remain greater than 90%. Skilled nursing visits on 1-9-13 and 1-11-13 failed to evidence any documentation the O2 sats had been completed.</p>	G000170	G 170 The Supervising Nurse will Inservice the Nursing Staff on policy Skilled Nursing Services. A pre and post test will be given to ensure learning needs have been met.10% of all clinical records will be audited quarterly for evidence that nursing is demonstrating competency in providing procedures and documenting and implementing physician orders. Any issue identified will be immediately addressed.The Supervising Nurse will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	04/10/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157090	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HERITAGE HOME HEALTH SERVICES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 801 PLAZA DR STE A MARTINSVILLE, IN 46151
---	---

(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. The agency's undated "Skilled Nursing Services" policy states, "Skilled nursing services will be provided .. in accordance with a medical provide Plan of care. ... 4. The nurse will demonstrate competency in providing procedures such as: ... c. Documenting and implementing physician orders."</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157090	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/11/2013
NAME OF PROVIDER OR SUPPLIER  HERITAGE HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 801 PLAZA DR STE A MARTINSVILLE, IN 46151		
(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	
N000000	<p>This was a state home health complaint investigation.</p> <p>Complaint # IN 00124961 - Unsubstantiated: Lack of sufficient evidence</p> <p>Survey Date: March 7-8 and 11, 2013</p> <p>Facility #: 005294</p> <p>Medicaid Vendor #: 100263560A</p> <p>Surveyor: Marty Coons, RN, PHNS</p> <p>Heritage Home Health Services is in compliance with 410 IAC Article 17, Rule 12, Sec. 1(d) as related to this complaint.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 15, 2013</p>	N000000			