

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  151571	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/19/2012
NAME OF PROVIDER OR SUPPLIER  SOUTHERNCARE FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 4666 W JEFFERSON STE 170 FORT WAYNE, IN 46804		
(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	
L0000	<p>This was a hospice Federal recertification and State licensure survey.</p> <p>Survey dates: July 16-19, 2012</p> <p>Facility number: IN002563</p> <p>Medicaid number: 200424070</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>July 23, 2012</p>	L0000	This does not appear to be a deficiency.		

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

TITLE

(X6) DATE

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

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L0578	<p><b>418.60 INFECTION CONTROL</b> The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.</p> <p>Based on employee file review, interview, and policy review, the agency failed to ensure its own infection control policy and procedure was followed for 1 of 9 employee files reviewed with the potential to affect all the patients of the agency. (E)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Employee file E, a Hospice Aide, date of hire 3/24/11, contained a Post-Hire Medical Questionnaire. This form failed to evidence a date of completion and a date of physician signature.</li> <li>2. The agency's policy titled "Employee Health Screenings," #SC-HR-106," with a review date of 07/01/10, states "All employees with patient contact will undergo a health screening to verify physical ability to perform designated job responsibilities and freedom from communicable disease prior to employment. PROCEDURE: A. Medical History Completion, ... 2. The hiring manager will forward the completed</li> </ol>	L0578	<p>L 578 418.60 Infection Control The administrator will review Policy SC-HR-106-Employee Health Screenings with the Local Administrator and Clinical Director to ensure that all employee medical files are reviewed, signed and dated by the Local Medical Director prior to the employee starting patient care. Responsible Parties: Administrator, Local Administrator, and Clinical Director. Completion Date: 8/1/12 Monitoring: The Clinical Director will review all new hire medical charts ongoing for the Local Medical Director's review, signature, and date prior to the employee starting patient care. No employee will be allowed to see patients until these requirements are met.</p>	08/01/2012			

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	<p>medical history (employee) to the local medical director to review, sign and return the day it is completed."</p> <p>3. On 7/19/12 at 2:00 PM, employee A indicated they did not realize the form was not signed and was not sure why the form was not signed.</p>			