

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151582	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2013
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NAME OF PROVIDER OR SUPPLIER SOUTHERNCARE SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 310 W MCKINLEY STE 340 MISHAWAKA, IN 46545
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(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
S000000	<p>This was a hospice state relicensure survey.</p> <p>Survey Dates: 5/21/13 to 5/22/13</p> <p>Facility Number: 003723</p> <p>Medicaid Vendor Number: 200451230</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Census: 193</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 24, 2013</p>	S000000		

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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S009997	<p>IC 16-28-13-4 Aide Registry Sec. 4(a) Except as provided in subsection (b), a person who:</p> <p>1) operates or administers a health care facility; or</p> <p>2) operates an entity in the business of contracting to provide nurse aides or other unlicensed employees for a health care facility;</p> <p>shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department...</p> <p>b) A health care facility is not required to apply for the state nurse aide registry report ... required by subsection (a) if the health care facility contracts to use the services of a nurse aide or other unlicensed employee who is employed by an entity in the business of contracting to provide nurse aides or other unlicensed employees to health care facilities.</p> <p>Based on personnel file review and interview, the agency failed to ensure the Hospice Aide was entered on and in good standing on the State Aide Registry for 2 of 4 Hospice Aide files reviewed with the potential to affect all the agency's patient's that receive Hospice Aide services. (employees D and G)</p> <p>Findings include:</p> <p>1. Personnel file D, date of hire 8/1/11, failed to evidence verification the</p>	S009997	<p>IC 16-28-13-4 Aide Registry The Clinical Director will review SC-HR-103 Background Screening OIG Exclusion List. RESPONSIBLE PARTY: Clinical Director MONITORING: The Clinical Director will fill out the correct form for the HHA Registry and send to Registry. Ongoing will be doing prior to hire on future Hospice Aides.</p>	06/24/2013			

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	<p>employee was entered on and in good standing on the state aide registry as a Hospice Aide. A document titled "Indiana Online Licensing" states, "License Type: Certified Nurse Aide."</p> <p>2. Personnel file G, date of hire 4/15/13, failed to evidence verification the employee was entered on and in good standing on the state aide registry as a Hospice Aide. A document titled "Indiana Online Licensing" states, "License Type: Certified Nurse Aide."</p> <p>3. On 5/22/13 at 3:17 PM, employee A, Director of Nursing, indicated employees D and G were Certified Nurses Aides and had not been placed on the registry.</p>			