

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151576	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/05/2012 12:00:C
NAME OF PROVIDER OR SUPPLIER ENTRUST HEALTH SERVICES INC COMMUNITY HOSPICE PRC			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 WEST 42ND STREET, SUITE 225 INDIANAPOLIS, IN46208		
(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	
S0000	<p>This visit was a hospice state licensure survey.</p> <p>Survey dates: January 4-5, 2012</p> <p>Facility number: 003313</p> <p>Medicaid number: 200393780</p> <p>Surveyors: Kelly Ennis, BSN, RN, PHNS, Team Leader Miriam Bennett, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 10, 2012</p>	S0000			
S0523	<p>The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.</p>				

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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	<p>Based on facility policy review, job description review, clinical record review, and interview, the hospice failed to ensure a comprehensive assessment was completed within 5 calendar days after the election of hospice care in 11 of 11 records reviewed. (#1-11)</p> <p>The findings include:</p> <ol style="list-style-type: none"> The hospice policy titled "Comprehensive Assessment - Initial" policy number: REG.C55 states, "Based on the needs and findings from the initial assessment, the hospice RN coordinates and designates disciplines that must participate in the comprehensive assessment of the patient within 5 days of his or her election of hospice care." The hospice policy titled "Bereavement Risk Assessment" policy number REG.B15 states, "During the comprehensive assessment of the patient, an initial bereavement assessment is conducted to determine the cultural, social and spiritual factors that may impact the ability of family members or other involved individuals to cope with the patient's death." 	S0523	<p>S05231. In-service all staff on policy and procedure for Hospice Comprehensive Initial Assessment, which will be completed within 5 days of hospice admission. 2. Clinical Service Director will review all Initial Assessments within 24 hours of admission, and document the date each discipline will complete the initial assessment within the 5 days of admission to the hospice program. The clinical service director will review all initial admissions for completion on the initial assessment within the 5 days of admission to the hospice program in the patient's clinical record. A Hospice Comprehensive check list has been initiated to ensure compliance. The IDG Team will monitor every 2 weeks, and charts will be audited every 30 days for compliance. 100% of the charts will be audited monthly by the QI for ongoing compliance.3. The Clinical Service Director will be responsible for ensuring that the Initial Assessment is completed within 5 days of admission to the hospice program.4. The deficiency was completed on January 20, 2012.</p>	01/20/2012	

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	<p>3. The hospice policy titled "Social Work Services" policy number REG.S15 states, "The comprehensive assessment of the patient includes a psychosocial assessment conducted by the Social Worker to evaluate the patient/caregiver's emotional, social, financial, and environmental resources and identify appropriate psychosocial problems, interventions and goals for the patient's plan of care."</p> <p>4. The job description titled, "Medical Social Worker" states, "performs comprehensive initial psychosocial and bereavement evaluations ... Documents comprehensive psychosocial information clearly and concisely in a timely manner, records initial contact information, oversee all patient/family visits, telephone contacts and referral actions and record in the Medical Record within a twenty-four (24) hour period."</p> <p>5. Clinical record #1, with an election and start of care date of 3/31/10, failed to evidence a comprehensive assessment had been completed no later than 5 calendar days after the election of hospice care. Employee M, Social Worker (SW), did not complete the initial psychosocial assessment until 4/6/10.</p>						

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	<p>6. Clinical record #2, with an election and start of care date of 8/4/11, failed to evidence a comprehensive assessment had been completed no later than 5 calendar days after the election of hospice care. Employee N, Registered Nurse (RN), did not complete the initial bereavement assessment until 12/1/11.</p> <p>7. Clinical record #3, with an election and start of care date of 9/30/11, failed to evidence a comprehensive assessment had been completed no later than 5 calendar days after the election of hospice care. Employee M, SW, did not date the initial psychosocial assessment, so it could not be determined if it was completed within 5 calendar days after the election of hospice care.</p> <p>8. Clinical record #4, with an election and start of care date of 3/26/10, failed to evidence a comprehensive assessment had been completed no later than 5 calendar days after the election of hospice care. The initial bereavement assessment, completed by employee L, RN, on 3/31/10, was not completed in its entirety.</p> <p>9. Clinical record #5, with an election</p>			

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	<p>and start of care date of 9/30/11, failed to evidence a comprehensive assessment had been completed no later than 5 calendar days after the election of hospice care. Employee M, SW, did not date the initial psychosocial assessment, so it could not be determined if it was completed within 5 calendar days after the election of hospice care.</p> <p>10. Clinical record #6, with an election and start of care date of 8/9/09, failed to evidence a comprehensive assessment had been completed no later than 5 calendar days after the election of hospice care. An initial bereavement assessment could not be located in the clinical record.</p> <p>11. Clinical record #7, with an election and start of care date of 11/3/11, failed to evidence a comprehensive assessment had been completed no later than 5 calendar days after the election of hospice care. Employee M, Social Worker (SW), did not complete the initial psychosocial assessment until 11/11/11.</p> <p>12. Clinical record #8, with an election and start of care date of 11/21/11, failed to evidence a comprehensive assessment had been completed no later than 5</p>				

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	<p>calendar days after the election of hospice care. Neither an initial bereavement assessment nor a psychosocial assessment could be located in the clinical record.</p> <p>13. Clinical record #9, with an election and start of care date of 8/20/10, failed to evidence a comprehensive assessment had been completed no later than 5 calendar days after the election of hospice care. Employee M, SW, did not date the initial psychosocial assessment, so it could not be determined if it was completed within 5 calendar days after the election of hospice care. The initial bereavement assessment, completed by employee L, RN, was not completed in its entirety and was not dated.</p> <p>14. Clinical record #10, with an election and start of care date of 1/14/11, failed to evidence a comprehensive assessment had been completed no later than 5 calendar days after the election of hospice care. Employee M, Social Worker (SW), dated the initial psychosocial assessment 1/20/2010.</p> <p>15. Clinical record #11, with an election and start of care date of 6/25/11, failed to evidence a comprehensive assessment</p>				

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S0524	<p>had been completed no later than 5 calendar days after the election of hospice care. An initial psychosocial assessment could not be located in the clinical record.</p> <p>16. On 1/5/12 at 6 PM, employee L, RN/Administrator, indicated the patients often decline the visits and this is why they are not made. Employee L indicated the attempts to contact the patient within the first 5 days should have been documented however.</p> <p>The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.</p>			

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	<p>Based on facility policy and clinical record review, the hospice failed to ensure a comprehensive assessment that identified the psychosocial, emotional, and spiritual needs of the patient / family was completed in 5 of 11 records reviewed. (#4, 6, 8, 9, and 11)</p> <p>The findings include:</p> <p>1. The hospice policy titled "Comprehensive Assessment - Initial" policy number: REG.C55 states, "Based on the needs and findings from the initial assessment, the hospice RN coordinates and designates disciplines that must participate in the comprehensive assessment of the patient within 5 days of his or her election of hospice care."</p> <p>2. The hospice policy titled "Bereavement Risk Assessment" policy number REG.B15 states, "During the comprehensive assessment of the patient, an initial bereavement assessment is conducted to determine the cultural, social and spiritual factors that may impact the ability of family members or other involved individuals to cope with the patient's death."</p>	S0524	<p>S05241. In-service all staff on the policy and procedure for completion of the Comprehensive Initial Assessment within 5 days of admission to the hospice program. Review of job descriptions for Social Service, Bereavement and all admission nurses. Clinical Service Director will work 1:1 with each discipline to ensure compliance within the 5 day Initial Assessment period.2. Clinical Service Director will review all Comprehensive Initial Assessments within 24 hours of Admission, and document the date each discipline will complete the Comprehensive Initial assessment within 5 days of admission to the hospice program. A Check off sheet has been implemented to ensure compliance.3. The Clinical Service Director will be responsible for ensuring that the Comprehensive Initial Assessment is completed within 5 days of admission to the hospice program. The IDG Team will monitor every 2 weeks, and charts will be audited every 30 days for compliance. 100% of the charts will be audited monthly by the QI for ongoing compliance. 4. The deficiency was completed on January 20, 2012.</p>	01/20/2012	

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	<p>3. The hospice policy titled "Social Work Services" policy number REG.S15 states, "The comprehensive assessment of the patient includes a psychosocial assessment conducted by the Social Worker to evaluate the patient/caregiver's emotional, social, financial, and environmental resources and identify appropriate psychosocial problems, interventions and goals for the patient's plan of care."</p> <p>4. Clinical record #4, with an election and start of care date of 3/26/10, failed to evidence the comprehensive assessment identified the psychosocial, emotional, and spiritual needs of the patient. The initial bereavement assessment, completed by employee L, RN on 3/31/10, was not completed in its entirety.</p> <p>5. Clinical record #6, with an election and start of care date of 8/9/09, failed to evidence the comprehensive assessment identified the psychosocial, emotional, and spiritual needs of the patient. An initial bereavement assessment could not be located in the clinical record.</p> <p>6. Clinical record #8, with an election and start of care date of 11/21/11, failed</p>			

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	<p>to evidence the comprehensive assessment identified the psychosocial, emotional, and spiritual needs of the patient. Neither an initial bereavement assessment nor a psychosocial assessment could be located in the clinical record.</p> <p>7. Clinical record #9, with an election and start of care date of 8/20/10, failed to evidence the comprehensive assessment identified the psychosocial, emotional, and spiritual needs of the patient. The initial bereavement assessment, completed by employee L, RN, on 3/31/10, was not completed in its entirety and was not dated.</p> <p>8. Clinical record #11, with an election and start of care date of 6/25/11, failed to evidence the comprehensive assessment identified the psychosocial, emotional, and spiritual needs of the patient. An initial psychosocial assessment could not be located in the clinical record.</p>				

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S0530	<p>[The comprehensive assessment must take into consideration the following factors:]</p> <p>(6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:</p> <ul style="list-style-type: none"> (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring. 				

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	<p>Based on policy review and clinical record review, the hospice failed to ensure the medication review was updated when there were medication changes in 3 of 11 clinical records reviewed. (#1, 2, and 6)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The policy titled "Medication - Management," policy number REG.M25 states, "A Drug Profile is maintained for every patient and includes a listing of the current medication orders for each patient and specifies whether the medication is or is not related to the patient's terminal illness." The policy titled "Medication - Orders," policy number REG.M30 states, "Both telephone and written orders for medications are documented in the patient's clinical record and include: date of the order, name of the medication, dose, route, frequency, purpose (if PRN and/or antibiotic) ... Orders for medications are documented in the patient's current medication profile ... A physician's order is needed to discontinue medications." Clinical record #1, with an election 	S0530	<p>05301. All Registered Nurses were in-serviced on the policy and procedures for medication management and medication orders. 100% of all client medication records were reviewed for medication updates and changes.2. All medication updates and changes will be updated on the medication profile within 24 hours of initial orders. A daily medication log book will be kept on all new and pending medication orders and checked daily by the clinical service director. 3. All RNs will be responsible for updating medications, per policy and procedure for each individual assigned patient, as changes and updates occur within, 24 hours of initial orders by a physician. The medication profile will be reviewed when changes/updates occur, and every 60 days by RN staff. The Clinical Service Director will monitor daily physician order changes. A daily medication log book will be kept to ensure all medication changes and updates are in compliance with Hospice policy and procedure, and to ensure that medication profiles have been updated daily. 100% of the charts will be monitored by the IDG team for documentation of medication changes/updates every 2 weeks. 100% of the charts will be audited monthly by the QI for ongoing compliance. The clinical service director will</p>	01/20/2012	

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	<p>and start of care date of 3/31/10, included a document titled "Client Medication Sheet" which stated, "Signature Page - Must be reviewed and signed every 60 days by the Nurse!" Review of the document indicated the client medication sheet was reviewed by employee C, RN, on 8/10/10 and then not reviewed again until 12/10/10, greater than 60 days.</p> <p>Review of the clinical record evidenced a physician order dated 4/15/10 for "Aleve (1) PO [by mouth] QD [every day] PRN [as needed] arthritic pain." Review of the "Client Medication Sheet," last reviewed 12/13/11, failed to include the order for Aleve.</p> <p>4. Clinical record #2, with an election and start of care date of 8/4/11, included a document titled "Client Medication Sheet" which was last revised 11/15/11.</p> <p>Review of the clinical record evidenced a physician order dated 12/5/11 for "Ativan 0.5 MG Q 6 hours PRN, anxiety [every 6 hours as needed]" and "Morphine 5 MG PO Q 2-3 HRS PRN SOB/PAIN [per mouth every 2-3 hours as needed for shortness of breath or pain]." The clinical record also included an order</p>		<p>be responsible for monitoring the daily log book for compliance so that this deficiency will be corrected and will not reoccur. 4. This deficiency was completed on January 20, 2012.</p>		

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	<p>dated 12/9/11 for "Coumadin 1 MG PO dly [by mouth daily]." Review of the "Client Medication Sheet," last revised 11/15/11, failed to include these orders.</p> <p>5. Clinical record #6, with an election and start of care date of 8/9/09, included a document titled "Client Medication Sheet" which was last reviewed 11/11/11 by employee N, RN.</p> <p>Review of the clinical record evidenced a physician order dated 8/13/09 for "Haldol 0.25 mg, TID [three times per day] as needed for restlessness/agitation." A physician order dated 10/26/09 for "Mineral Oil 1-2 tbs [tablespoons] PO PRN [by mouth as needed] constipation." A physician order dated 11/25/09 for "Megace Elixir 625 mg, 1 teaspoon PO every day for Appetite Stimulant." Review of the "Client Medication Sheet," last revised 1/5/10, failed to include these orders.</p>				

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S0531	[The comprehensive assessment must take into consideration the following factors:] (7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.				

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	<p>Based on facility policy and clinical record review, the hospice failed to ensure an initial bereavement assessment was completed in 5 of 11 records reviewed. (#2, 4, 6, 8, and 9)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The hospice policy titled "Comprehensive Assessment - Initial" policy number: REG.C55 states, "Based on the needs and findings from the initial assessment, the hospice RN coordinates and designates disciplines that must participate in the comprehensive assessment of the patient within 5 days of his or her election of hospice care." 2. The hospice policy titled "Bereavement Risk Assessment" policy number REG.B15 states, "During the comprehensive assessment of the patient, an initial bereavement assessment is conducted to determine the cultural, social and spiritual factors that may impact the ability of family members or other involved individuals to cope with the patient's death." 3. Clinical record #2, with an election and start of care date of 8/4/11, failed to 	S0531	<p>S0531 1. In-service all staff on policy and procedure for Hospice Comprehensive Initial Assessment which will be completed within 5 days of hospice admission, which includes Bereavement assessment. 2. Clinical Service Director will review all Initial Assessment within 24 hours of admission and document the date each discipline will complete the initial assessment within the 5 days of admission to the hospice program. The clinical service director will review all initial admission for completion on the initial assessment within the 5 days of admission to the hospice program in the patient's clinical record. A comprehensive assessment tool for documentation of completion has been implemented. The Hospice IDG team will monitor for change and compliance every 2 weeks so that this deficiency does not reoccur. 100% of the charts will be audited monthly by the QI for ongoing compliance. 3. The Clinical Service Director will be responsible for ensuring that the Initial Bereavement Assessment is completed within 5 days of admission to the hospice program.4. The deficiency was completed on January 20, 2012.</p>	01/20/2012	

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	<p>evidence a comprehensive assessment had been completed no later than 5 calendar days after the election of hospice care. Employee N, Registered Nurse (RN), did not complete the initial bereavement assessment until 12/1/11.</p> <p>4. Clinical record #4, with an election and start of care date of 3/26/10, failed to evidence a comprehensive assessment had been completed no later than 5 calendar days after the election of hospice care. The initial bereavement assessment, completed by employee L, RN, on 3/31/10, was not completed in its entirety.</p> <p>5. Clinical record #6, with an election and start of care date of 8/9/09, failed to evidence a comprehensive assessment had been completed no later than 5 calendar days after the election of hospice care. An initial bereavement assessment could not be located in the clinical record.</p> <p>6. Clinical record #8, with an election and start of care date of 11/21/11, failed to evidence a comprehensive assessment had been completed no later than 5 calendar days after the election of hospice care. An initial bereavement</p>				

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S0543	<p>assessment could not be located in the clinical record.</p> <p>7. Clinical record #9, with an election and start of care date of 8/20/10, failed to evidence a comprehensive assessment had been completed no later than 5 calendar days after the election of hospice care. The initial bereavement assessment, completed by employee L, RN, on 3/31/10, was not completed in its entirety and was not dated.</p> <p>All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.</p>				

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	<p>Based on facility policy and clinical record review, the hospice failed to ensure home hospice aide visits and social work visits were made as ordered in 7 of 11 records reviewed. (#1, 2, 3, 4, 6, 7, and 9).</p> <p>The findings include:</p> <p>1. The hospice policy titled "Plan of Care" policy number: REG.P25 states, "Hospice care and services provided to patients and their families are in accordance with an individualized, written plan of care."</p> <p>2. The hospice policy titled "Social Work Services" policy number: REG.S15 states, "Social work services are provided in accordance with recognized standards of practice and the patient's plan of care, based on the initial and comprehensive assessments of patient / caregiver needs ... The Social Worker provides services to the patient / caregiver in accordance with the patient's plan of care. Visit frequencies, specified in the plan of care, are determined based on the individualized, assessed needs of the patient / caregiver."</p>	S0543	<p>05431. All staff was in-serviced on Hospice Policy & Procedures for hospice care, and services provided to patients and their families in accordance with an individualized written plan of care. 2. Any changes in visit frequency will be documented in the individualized plan of care at time of orders for changes in visit frequency. Any frequency in change of visits will be documented in the individualized patient plan of care. The Plan of care will be updated immediately when there is a change in the frequency of each discipline. A review of the changes to the plan of care will be documented and communicated to members of the IDG. 3. The IDG will monitor 100% of the patient records for documentation of visit frequency changes every 2 weeks. 100% of the charts will be audited monthly by the QI for ongoing compliance. The Clinical Service Director will be responsible to ensure that this process is done. 4. This deficiency was completed on January 20, 2012.</p>	01/20/2012	

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	<p>3. The job description titled "Home Health Aide" states, "An individual who, under the direction of a Registered Nurse, provides personal care services within the guidelines of the Interdisciplinary Team Care Plan to patient enrolled in the Center for Hospice Care, Inc. program."</p> <p>4. Clinical record #1, with an election date of 3/31/10 and an established plan of care date of 11/21/11, identified MSW (Social Worker) visits were to occur "1x/mo / 60 days [1 time per month for 60 days]." The record failed to evidence any MSW visits had been made for the election period 11/21/11 to 1/19/12.</p> <p>5. Clinical record #2, with an election date of 8/4/11 and an established plan of care date of 11/2/11, identified MSW visits were to occur "1x/mo / 60 days [1 time per month for 60 days]." Review of the record evidenced 1 MSW visit was made on 12/7/11, greater than 1 month after the established plan of care date of 11/2/11.</p> <p>6. Clinical record #3, with an election date of 9/30/11 and an established plan of care date of 9/30/11, identified MSW visits were to occur "1x/mo / 60 days [1</p>						

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	<p>time per month for 60 days]." The record failed to evidence any MSW visits were made for the election period 9/30/11 to 12/28/11.</p> <p>7. Clinical record #4, with an election and start of care date of 3/26/10 and an established plan of care date of 11/16/11, identified MSW visits were to occur "1x/mo / 60 days [1 time per month for 60 days]" and Hospice Aide (HA) visits were to occur "5x/wk / 60 days [5 times per week for 60 days]." The record failed to evidence any MSW visits had been made for the election period 11/16/11 to 1/14/11. The record also failed to evidence 5 HA visits were made the week of 11/20/11.</p> <p>8. Clinical record #6, with an election date of 8/9/09 and an established plan of care date of 11/26/11, identified MSW visits were to occur "1x/mo / 60 days [1 time per month for 60 days]." The record failed to evidence any MSW visits had been made for the election period 11/26/11 to 1/24/11.</p> <p>9. Clinical record #7, with an election date of 11/3/11 and an established plan of care date of 11/3/11, identified MSW visits were to occur "1x/mo / 60 days [1</p>				

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	<p>time per month for 60 days] and HA visits were to occur "5x/wk / 60 days [5 times per week for 60 days]." Review of the record evidenced only 1 MSW visit was made, on 11/11/11, between the time period reviewed from 11/3/11 to 1/5/12. The record also failed to evidence 5 HA visits were made the week of 11/6/11 and 11/20/11.</p> <p>10. Clinical record #9, with an election date of 8/20/10 and an established plan of care date of 10/14/11, identified MSW visits were to occur "1x/mo / 60 days [1 time per month for 60 days] and HA visits were to occur "5x/wk / 60 days [5 times per week for 60 days]." Review of the record evidenced no MSW visits were made for election period 10/14/11 to 12/12/11. The record also failed to evidence 5 HA visits were made the weeks of 10/16/11, 10/23/11, 10/30/11, 11/6/11, 11/13/11, 11/20/11, and 11/27/11.</p>				

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S0594	Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services.				

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	<p>Based on facility policy review, job description review, and clinical record review, the hospice failed to ensure psychosocial assessments were conducted on all patients and medical social services were provided in accordance with the plan of care in 9 of 11 records reviewed. (#1, 2, 3, 4, 6, 7, 8, 9, and 11).</p> <p>The findings include:</p> <p>1. The hospice policy titled "Social Work Services" policy number: REG.S15 states, "Social work services are provided in accordance with recognized standards of practice and the patient's plan of care, based on the initial and comprehensive assessments of patient / caregiver needs ... The comprehensive assessment of the patient includes a psychosocial assessment conducted by the Social Worker to evaluate the patient / caregiver's emotional, social, financial, and environmental resources and identify appropriate psychosocial problems, interventions and goals for the patient's plan of care .. The Social Worker provides services to the patient/caregiver in accordance with the patient's plan of care. Visit frequencies, specified in the</p>	S0594	0594 1. Medical Social Worker was in-serviced on Hospice Policy & Procedures for social work services, which include the Comprehensive Assessment, visits frequency specified in the individualized plan of care. As identifiable patient/family needs change, the visit frequency will be documented in the patient's record. 2. Review of changes in visit frequency will be monitored by the IDG team every 2 weeks and documented in patient's clinical records. 3. The IDG team and clinical director will be responsible for ensuring that this deficiency will not reoccur. 100% of the medical records will be reviewed by the IDG team every 2 weeks for compliance. 100% of the charts will be audited monthly by the QI for ongoing compliance. 4. This deficiency was completed on January 20, 2012.	01/20/2012	

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	<p>plan of care, are determined based on the individualized, assessed needs of the patient / caregiver."</p> <p>2. The job description titled, "Medical Social Worker" states, "performs comprehensive initial psychosocial and bereavement evaluations ... Documents comprehensive psychosocial information clearly and concisely in a timely manner, records initial contact information, oversee all patient / family visits, telephone contacts and referral actions and record in the Medical Record within a twenty-four (24) hour period."</p> <p>3. Clinical record #1, with an election date of 3/31/10 and an established plan of care date of 11/21/11, identified MSW (Social Worker) visits were to occur "1x/mo / 60 days [1 time per month for 60 days]." The record failed to evidence any MSW visits had been made for the election period 11/21/11 to 1/19/12.</p> <p>4. Clinical record #2, with an election date of 8/4/11 and an established plan of care date of 11/2/11, identified MSW visits were to occur "1x/mo / 60 days [1 time per month for 60 days]." Review of the record evidenced 1 MSW visit was made on 12/7/11, greater than 1 month</p>						

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	<p>after the established plan of care date of 11/2/11.</p> <p>5. Clinical record #3, with an election date of 9/30/11 and an established plan of care date of 9/30/11, identified MSW visits were to occur "1x/mo / 60 days [1 time per month for 60 days]." The record failed to evidence any MSW visits were made for the election period 9/30/11 to 12/28/11.</p> <p>6. Clinical record #4, with an election and start of care date of 3/26/10 and an established plan of care date of 11/16/11, identified MSW visits were to occur "1x/mo / 60 days [1 time per month for 60 days]." The record failed to evidence any MSW visits had been made for the election period 11/16/11 to 1/14/11.</p> <p>7. Clinical record #6, with an election date of 8/9/09 and an established plan of care date of 11/26/11, identified MSW visits were to occur "1x/mo / 60 days [1 time per month for 60 days]." The record failed to evidence any MSW visits had been made for the election period 11/26/11 to 1/24/11.</p> <p>8. Clinical record #7, with an election</p>				

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	<p>date of 11/3/11 and an established plan of care date of 11/3/11, identified MSW visits were to occur "1x/mo / 60 days [1 time per month for 60 days]." Review of the record evidenced only 1 MSW visit was made, on 11/11/11, between the time period reviewed from 11/3/11 to 1/5/12.</p> <p>9. Clinical record #8, with an election and start of care date of 11/21/11, failed to evidence the comprehensive assessment included a psychosocial assessment. Review of record failed to evidence an initial psychosocial assessment was completed.</p> <p>10. Clinical record #9, with an election date of 8/20/10 and an established plan of care date of 10/14/11, identified MSW visits were to occur "1x/mo / 60 days [1 time per month for 60 days]." The record failed to evidence any MSW visits were made for election period 10/14/11 to 12/12/11.</p> <p>11. Clinical record #11, with an election and start of care date of 6/25/11, failed to evidence the comprehensive assessment included a psychosocial assessment. Review of record failed to evidence an initial psychosocial</p>				

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S0626	assessment was completed. (2) A hospice aide provides services that are: (i) Ordered by the interdisciplinary group. (ii) Included in the plan of care. (iii) Permitted to be performed under State law by such hospice aide. (iv) Consistent with the hospice aide training.				

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	<p>Based on job description review and clinical record review, the hospice failed to ensure the hospice aide provided services included in the plan of care in 4 of 11 records reviewed (#1, 3, 7, and 11).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The job description titled "Home Health Aide" states, "An individual who, under the direction of a Registered Nurse, provides personal care services within the guidelines of the Interdisciplinary Team Care Plan to patient enrolled in the Center for Hospice Care, Inc. program." 2. Clinical record #1, with an election date of 3/31/10 and an established plan of care date of 11/21/11, included a "HHA Care Plan" with hospice aide care plan orders for "Bed bath -partial / complete; personal care; assist with dressing; skin care / foot care (hygiene); shave / groom / deodorant; nail hygiene - Clean / file / report (do not cut); mobility assist - chair / bed / dangle / commode / shower / tub; light housekeeping bedroom / bathroom / kitchen / change bed linen; equipment care: w/c [wheelchair], walker, bedside commode." 	S0626	<p>SO6261. Hospice home health aides were In-serviced 1:1 on the home health aide job description and the hospice aide care plan in compliance with the guidelines of the Inter disciplinary team care plan. 2. RN supervisor will review and supervise hospice aide every 2 weeks for compliance. All updates and changes will be reviewed by RN with hospice aide before any patient care is received. RN and hospice aide will document in patient's clinical records, that care plan changes have been updated and changes made.3. RN supervisor will be responsible by reviewing the hospice plan of care with hospice aide, as patient needs changes, and document in patient's clinical records. RN supervisor will be responsible to ensure that these defieicies do not reoccur. IDG will monitor for compliance every 2 weeks. 100% of the charts will be audited monthly by the QI for ongoing compliance.4. The deficiency was completed on January 20, 2012.</p>	01/20/2012	

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	<p>"Aide Activity Flow Sheet" notes from 11/20/11, 11/23/11, 11/29/11, 12/2/11, 12/6/11, 12/9/11, 12/13/11, 12/16/11, 12/20/11, and 12/23/11 to 1/19/12 revealed employee A, Hospice Aide (HA), gave the patient a shower, provided hair care, checked pressure areas, and applied stockings. None of these tasks were listed on the "HHA Care Plan."</p> <p>3. Clinical record #3, with an election date of 9/30/11 and an established plan of care date of 9/30/11, included a "HHA Care Plan" with hospice aide care plan orders for "Tub / Sponge / Shower; Bed bath -partial/complete; Assist Bath - Chair; assist with dressing; hair care - Brush / shampoo / other; skin care / foot care (hygiene); check pressure areas; nail hygiene - Clean / file / report (do not cut); oral care - brush / swab / dentures; ambulation assist W/C / Walker / Cane."</p> <p>"Aide Activity Flow Sheet" notes from 10/4/11, 10/5/11, 10/7/11, 10/12/11, 10/14/11, 10/15/11, 10/17/11, 10/19/11, 10/21/11, 10/23/11, 10/25/11, 10/27/11, 10/30/11, 11/1/11, 11/3/11, 11/7/11, 11/9/11, 11/11/11, 11/14/11, 11/16/11, 11/18/11, 11/20/11, 11/21/11, 11/23/11, 11/28/11, 11/30/11, and 12/2/11 revealed employee A, HA, applied</p>				

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	<p>deodorant to patient and performed light housekeeping. None of these tasks were listed on the "HHA Care Plan."</p> <p>4. Clinical record #7, with an election date of 11/3/11 and an established plan of care date of 11/3/11, included a "HHA Care Plan" with hospice aide care plan orders for "Assist with dressing; skin care/foot care (hygiene)." Review of "Aide Activity Flow Sheet" notes revealed the following:</p> <p>A. On 11/11/11, employee A, HA, provided hair care and checked pressure areas. None of these tasks were listed on the "HHA Care Plan."</p> <p>B. On 11/14/11, 11/15/11, 11/16/11, 11/17/11, and 11/18/11, employee A, HA, provided hair care, checked pressure areas, provided medication reminders, and performed light housekeeping. None of these tasks were listed on the "HHA Care Plan." None of these tasks were listed on the "HHA Care Plan."</p> <p>C. On 11/20/11, 11/23/11, 11/29/11, and 12/2/11, employee A, HA, provided a shower, hair care, checked pressure areas, provided deodorant, and performed light housekeeping. None of</p>			

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	<p>these tasks were listed on the "HHA Care Plan."</p> <p>D. On 11/21/11, 11/22/11, 11/28/11, 11/30/11, and 12/1/11 employee A provided a sponge bath, hair care, checked pressure areas, provided deodorant, and performed light housekeeping. None of these tasks were listed on the "HHA Care Plan."</p> <p>E. On 12/5/11, 12/9/11, 12/12/11, 12/17/11, 12/21/11, and 12/23/11, employee A provided a shower, hair care, checked pressure areas, provided medication reminders, and performed light housekeeping. None of these tasks were listed on the "HHA Care Plan."</p> <p>F. On 12/6/11, 12/7/11, 12/8/11, 12/13/11, 12/14/11, 12/15/11, 12/19/11, 12/20/11, and 12/22/11, employee A provided a sponge bath, hair care, checked pressure areas, provided medication reminders, and performed light housekeeping. None of these tasks were listed on the "HHA Care Plan."</p> <p>5. Clinical record #11, with an election date of 6/25/11 and an established plan of care date of 6/25/11, included a "HHA Care Plan" with hospice aide care plan</p>				

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	<p>orders for "Bed bath -partial/complete; assist with dressing; skin care / foot care (hygiene); shave / groom / deodorant; nail hygiene - Clean / file / report (do not cut); ambulation assist W/C / Walker / Cane; meal preparation; wash clothes; light housekeeping." Review of "Aide Activity Flow Sheet" notes revealed the following:</p> <p>A. On 6/28/11 and 6/30/11, employee A provided a sponge bath. None of these tasks were listed on the "HHA Care Plan."</p> <p>B. On 7/5/11, 7/18/11, and 7/21/11, employee A provided a sponge bath and checked pressure areas. None of these tasks were listed on the "HHA Care Plan."</p> <p>C. On 7/7/11, employee A provided a sponge bath, checked pressure areas, and provided elimination assistance. None of these tasks were listed on the "HHA Care Plan."</p> <p>D. On 7/13/11, 7/14/11, and 7/16/11, employee A provided a sponge bath. None of these tasks were listed on the "HHA Care Plan."</p> <p>E. On 7/25/11 and 7/27/11, employee A provided a sponge bath and provided</p>				

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S0647	elimination assistance. None of these tasks were listed on the "HHA Care Plan." Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked.			

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	<p>Based on facility policy review, administrative document review, and interview, it was determined the hospice failed to provide documentation that volunteers were providing a minimum of 5 percent of the total patient care hours of all paid hospice employees and contract staff for 1 of 1 hospice surveyed.</p> <p>The findings include:</p> <p>1. The hospice policy titled "Volunteers - Recordkeeping", policy number: REG.V10 states, "Data from the monthly volunteer activity summaries is compiled annually to document and demonstrate that the services provided by hospice volunteers equals or exceeds five (5) percent of the total patient care hours of all paid hospice employees and contract staff ... The annual volunteer data is tabulated by January 30th of the following year and is submitted to the hospice Administrator."</p> <p>2. Review of the volunteer log book failed to evidence documentation that volunteers were providing a minimum of 5 percent of the total patient care hours of all paid hospice employees and contract staff.</p>	S0647	<p>SO6471. Hospice administrator In-serviced the volunteer coordinator on hospice policy and record keeping. The 2011 Volunteer Log was located.2. A volunteer coordinator will keep a log of all volunteer hours on a bi-weekly basis and monitor compliance on a monthly basis. The volunteer log book will be kept in a designated area for easy reference.3. Administrator will monitor monthly to ensure that this deficiency does not reoccur. An audit will be completed every month by the QI to ensure compliance.4. The deficiency was completed on January 20, 2012.</p>	01/20/2012	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/03/2012

FORM APPROVED

OMB NO. 0938-0391

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S0678	<p>3. During an interview on 1/5/12 at 4:30 PM, employee L, RN/Administrator, indicated they used to have a form that showed the volunteers were meeting the 5% requirement, but it was lost when they moved offices and could not be located.</p> <p>[Each patient's record must include the following:] (7) Physician orders.</p>				

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	<p>Based on policy review and clinical record review, the hospice failed to ensure the clinical record contained physician orders for all medications provided in 2 of 11 active clinical records reviewed. (#7 and 8)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The policy titled "Medication - Management," policy number REG.M25 states, "All medications are ordered by a licensed physician." The policy titled "Medication - Orders," policy number REG.M30 states, "Both telephone and written orders for medications are documented in the patient's clinical record and include: date of the order, name of the medication, dose, route, frequency, purpose (if PRN and/or antibiotic) ... Orders for medications are documented in the patient's current medication profile ... No change may be made to the medication dosage or route without a physician's order ... A physician's order is needed to discontinue medications." Clinical record #7, with an election and start of care date of 11/3/11, 	S0678	<p>S0678 1. All RN's were in-serviced on policy and procedures for medication management and medication orders. For those clients released from the hospital or nursing home with a current list of discharged medications, RN will re-verify all medications with primary care physician within 24 hours of admission or re-admission to agency. All medications will be updated on the medication profile daily. All medications administered to patients must have a physician's order. For any orders found to be missing or incorrectly filed, a duplicate copy of the order will be obtained from the prescribing physician and placed in the patient's medical record. Agency will discontinue practice of verifying meds from hospital or nursing home discharge summary only. 2. 100% of clinical records will be monitored daily for physician medication order changes/updates, by the Clinical Service Director. All medication orders will be documented on the Physician Order form, and a copy placed in the patient record. 100% of clinical records will be audited monthly for compliance by QI that physician orders for medication/ changes/updates are being documented in the patient's clinical record, per agency policy and procedure for Medication Orders. 3. The clinical service director will be responsible for</p>	01/20/2012	

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	<p>included a "Client Medication Profile" last reviewed by employee L, RN/Administrator, on 1/1/12. Review of the "Client Medication Profile" evidenced the following:</p> <p>A. On 11/3/11, the "Client medication profile" was updated to include "Flagyl 375 MG Cap (open cap and apply to wound under r [right] arm, daily); cleanse wound daily w/normal saline, for wound care."</p> <p>B. On 12/15/11, the "Client medication profile" was updated to include "Lasix 40 mg, qD [every day] at 9 AM for edema" and K+ 10 Mcg, qD, 9 AM, K+ supplement [Potassium 10 MCG, every day at 9 Am, for Potassium supplement]."</p> <p>C. Review of the clinical record failed to provide evidence of an order for these medications.</p> <p>4. Clinical record #8, with an election and start of care date of 11/21/11, included a "Client Medication Profile" last reviewed by employee L, RN/Administrator, on 11/23/11. Review of the "Client Medication Profile" evidenced the following:</p>		<p>monitoring and ensuring that this deficiency is corrected. A daily medication log has been put in place to monitor and track all new medication changes/updates. The medication log will be used to identify daily medication changes and updates, to ensure physician's orders are implemented and medications are documented in patient's clinical records so that this deficiency will not reoccur. 4. This deficiency was completed on January 20, 2012.</p>		

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S0679	<p>A. On 11/22/11, the "Client medication profile" was updated to include "Lorazepam 0.5 MG PO TID [by mouth three times per day] for nerves," "Senna S 1 PO BID [by mouth two times per day]," and "Vicodin 5/500 MG PO Q 6 Hours PRN Pain [by mouth every 6 hours as needed for pain]."</p> <p>B. On 12/15/11, the "Client medication profile" was updated to include "Lasix 40 mg, qD [every day] at 9 AM for edema" and "K+ 10 Mcg, qD, 9 AM, K+ supplement [Potassium 10 MCG, every day at 9 Am, for Potassium supplement]."</p> <p>C. Review of the clinical record failed to provide evidence of an order for these medications.</p> <p>All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.</p>				

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	<p>Based on job description review, clinical record review, and interview, the hospice failed to ensure the clinical record contained entries that were complete and appropriately authenticated and dated in 5 of 11 clinical records reviewed. (#3, 4, 5, 9 and 10)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The job description titled "Medical Social Worker" states, "Documents comprehensive psychosocial information clearly and concisely in a timely manner, records initial contact information, Oversee all patient / family visits, telephone contacts and referral actions and record in the Medical Record within a twenty-four (24) hours period." The job description titled "Bereavement Coordinator" states, "Maintain proper records of visits to patients / families." Clinical record #3, with an election and start of care date of 9/30/11, included an initial psychosocial assessment completed by Employee M, social worker (SW), that was not dated. 	S0679	<p>S0679 1. Medical Social Workers were In-serviced 1:1 on job description, and the completion process for the comprehensive psychosocial, spiritual, and bereavement assessments. 1:1 corrective action plan has been put in place to ensure that SW clinical record entries are dated, completed, and appropriately authenticated. A comprehensive Hospice Assessment Check off form has been implemented to ensure that this deficiency practice will not reoccur. 2. The Clinical Director will monitor the admission process of all new admissions to the hospice program to ensure all elements of the assessment are completed within the 5 day time frame. The Clinical Service Director will review each admission record to be sure each is authenticated, dated, and complete. A Comprehensive Hospice Documentation Form has been added for each discipline to check off when the assessment is complete within the 5 day time frame of admission to the hospice program. 3. 100% of the charts will be monitored every 2 weeks by the IDG team. 100% of all client records will be audited monthly by QI, for evidence that documents are dated and a completed comprehensive patient assessment was done within 5 days of admission to the hospice program. 4. This deficiency was completed on January 20, 2012.</p>	01/20/2012	

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	<p>4. Clinical record #4, with an election and start of care date of 3/26/10, included an initial bereavement assessment, completed by employee L, registered nurse (RN) on 3/31/10, that was not completed in its entirety.</p> <p>5. Clinical record #5, with an election and start of care date of 9/30/11, included an initial psychosocial assessment completed by Employee M, SW, that was not dated.</p> <p>6. Clinical record #9, with an election and start of care date of 8/20/10, included an initial psychosocial assessment completed by Employee M, SW, that was not dated. The clinical record also contained an initial bereavement assessment, completed by employee L, RN, that was not completed in its entirety and was not dated.</p> <p>7. Clinical record #10, with an election and start of care date of 1/14/11, included an initial psychosocial assessment completed by Employee M, SW, that was incorrectly dated 1/20/2010, the wrong year.</p> <p>8. On 1/5/11 at 6:10 PM, employee L, RN/Administrator, indicated that all</p>				

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S9997	<p>documents should be signed and dated.</p> <p>Sec. 4(a) Except as provided in subsection (b), a person who:</p> <ol style="list-style-type: none"> 1) operates or administers a health care facility; or 2) operates an entity in the business of contracting to provide nurse aides or other unlicensed employees for a health care facility; <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>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151576	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/05/2012 12:00:C
NAME OF PROVIDER OR SUPPLIER ENTRUST HEALTH SERVICES INC COMMUNITY HOSPICE PRC			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 WEST 42ND STREET, SUITE 225 INDIANAPOLIS, IN46208		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>Based on personnel record review and interview, the hospice failed to ensure the state aide registry was accessed to obtain a copy of the person's state nurse aide registry report in 1 of 2 hospice aide records reviewed (Personnel Record A).</p> <p>The findings include:</p> <ol style="list-style-type: none"> Personnel record A, date of hire 2/8/2009, failed to evidence the hospice had contacted the state aide registry for a copy of the aide's registry report. <p>A document titled "Indiana Online Licensing" indicated the license type of employee A was a "Certified Nurse Aide."</p> <ol style="list-style-type: none"> On 1/5/2012, at 5:45 PM, employee K, secretary, indicated the state aide registry was not accessed for employee A. 	S9997	<p>S99971. Office manager and home health aides were In-serviced on assessing State Nurses Registry. 2. Office manager will verify all new aides have registered with the State. A log will be kept by office manager and checked daily for compliance.3. Office manager and clinical service director will be responsible for registering home health aides with the ISDH Registry. 4. The deficiency was completed on January 20, 2012.</p>	01/20/2012	