

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BLESSED HANDS HOME CARE AGENCY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3221 S MICHIGAN STREET SOUTH BEND, IN 46614
--	---

(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
G 000 Bldg. 00	<p>This visit was for a home health federal initial Medicaid certification survey. This was a partial extended survey.</p> <p>Survey Dates: May 13, 14, and 15, 2015</p> <p>Facility #: 013427</p> <p>Medicaid #: N/A</p> <p>Census (Unduplicated) last 12 months: 12</p> <p>QR: JE 5/19/15</p>	G 000		
G 159 Bldg. 00	<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 clinical record review, policy review, observation, and interview, the</p>	G 159	Agency administrator educated self on proper documentation on DME and equipment.	05/20/2015

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:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2015	
NAME OF PROVIDER OR SUPPLIER BLESSED HANDS HOME CARE AGENCY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3221 S MICHIGAN STREET SOUTH BEND, IN 46614			
(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>agency failed to ensure all durable medical equipment in the home was included on the plan of care for 1 of 7 active records reviewed (#1) and failed to ensure frequency of visits was included on the plan of care for 1 of 7 active patient records reviewed (#8).</p> <p>Findings include:</p> <p>1. Clinical record #1 contained a Home Health Certification and Plan of Care for certification period 3/15 to 5/15/15 that failed to list durable medical equipment in the home.</p> <p style="padding-left: 40px;">A. On 5/15/15 at 10:40 AM at a home visit with patient #1, a cane, motorized wheel chair, and grab bars in the bathroom next to the commode and in the shower were observed.</p> <p style="padding-left: 40px;">B. On 5/15/15 at 11:25 AM, employee C (administrator-alternate director of nursing) indicated being unaware the equipment needed to be included on the plan of care because the patient had the equipment before admission and the equipment was not provided by the agency.</p> <p>2. Clinical record #8 contained a Home Health Certification and Plan of Care for certification period 9/14 to 11/12/14 that</p>		<p>Administrator to educate all new and incoming RN staff. To prevent re-occurrence Administrator will continue to re-educate staff on DME equipment documentation. Administrator to implement a DME equipment checklist to give to RN supervisors to complete during supervisory visits. Administrator will review charts monthly to ensure checklist is being used efficiently. Administrator wrote a clarification order to correct plan of treatment for chart #1 and #8</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2015	
NAME OF PROVIDER OR SUPPLIER BLESSED HANDS HOME CARE AGENCY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3221 S MICHIGAN STREET SOUTH BEND, IN 46614			
(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			
N 000 Bldg. 00	<p>failed to include the skilled nurse visit frequency.</p> <p>A. The record evidenced a document dated 9/14/14 titled "Patient Case Conference" stating, "1 [one] SN [skilled nursing] visit q [every] 3 days to change dressing to nephrostomy site."</p> <p>B. On 5/14/15 at 12:15 PM, employee B (owner, office staff) indicated the skilled nursing visit was 1 time every 3 days and that frequency was not listed on the plan of care.</p> <p>3. The undated agency policy titled "Care Plan" states, "Development of Care Plan ... Steps to be taken in developing the care plan include: 1. Collection of baseline data including all pertinent diagnoses, including mental status, types of services, ... equipment required, frequency and duration of visits"</p> <p>This visit was for a state home health re-licensure survey.</p> <p>Survey Dates: May 13, 14, and 15, 2015</p> <p>Facility #: 013427</p>	N 000					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BLESSED HANDS HOME CARE AGENCY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3221 S MICHIGAN STREET SOUTH BEND, IN 46614
--	---

(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
N 456 Bldg. 00	<p>Medicaid #: N/A</p> <p>Census (Unduplicated) last 12 months: 12</p> <p>QR: JE 5/19/15</p> <p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p> <p>Based on agency document review and interview, the administrator failed to ensure the agency had an ongoing quality assurance program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, resolve identified problems, and improve patient care for 1 of 1 agency.</p> <p>Findings include:</p> <p>1. Review of agency documents failed to evidence the agency had a functioning quality improvement program.</p>	N 456	<p>Agency administrator will implement and maintain a QAPI program for the agency. Administrator along with the Board of Directors to implement a QAPI committee; consisting of 1 Hha/CNA, 1 field nurse, 1 office personnel, and the Administrator. The committee will collect data to identify trends and areas that may need improvement and revision. The administrator will identify trends by: 1. Reviewing all staff assignments and patient care provided to ensure that the clinical decision is made with the patient's care and welfare in mind and that the clinical decision making is not endangered when incentives are provided to staff. This includes advising and</p>	05/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2015
NAME OF PROVIDER OR SUPPLIER BLESSED HANDS HOME CARE AGENCY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3221 S MICHIGAN STREET SOUTH BEND, IN 46614		
(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	
N 472 Bldg. 00	<p>2. On 5/15/15 at 12:15 PM, employee C (administrator-alternate director of nursing) indicated there had been no collection of data to incorporate into the quality improvement program. The employee indicated there had been client satisfaction surveys, but they had not been included as part of the program.</p> <p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on administrative document review and interview, the agency failed to implement and maintain a quality assessment and performance improvement program that reflected the complexity of services, including actions to improve the home health agency's</p>	N 472	<p>consulting with management regarding quality improvement issues.2. Review all incident reports, patient and physician questionnaires, monitoring and evaluation activities and any other activities deemed appropriate for QAPI review.3. Report results of QAPI activities to the Professional Advisory Committee, Administrator and field personnel through written reports and staff meetings.4. Maintain all data regarding QAPI in a confidential manner and ensure absence of individual patient identification reports.</p> <p>Agency administrator will implement and maintain a QAPI program for the agency. Administrator and Board of Directors to form QAPI committee; consisting of 1 Hha/CNA, 1 field nurse, 1 office staff, and the administrator. The</p>	05/20/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2015	
NAME OF PROVIDER OR SUPPLIER BLESSED HANDS HOME CARE AGENCY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3221 S MICHIGAN STREET SOUTH BEND, IN 46614			
(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			
N 524 Bldg. 00	<p>performance use objective measures for 1 of 1 agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of agency documents failed to evidence the agency had a functioning quality improvement program. 2. On 5/15/15 at 12:15 PM, employee C (administrator-alternate director of nursing) indicated there had been no collection of data to incorporate into the quality improvement program. The employee indicated there had been client satisfaction surveys, but they had not been included as part of the program. <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (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: (i) Mental status.</p>		<p>committee will collect data to identify trends and areas that may need improvement and revision. Administrator to identify trends by:1. Review all staff assignments and patient care provided to ensure that the clinical decision is made with the patient's care and welfare in mind and that the clinical decision making is not endangered when incentives are provided to staff. This includes advising and consulting with management regarding quality improvement issues.2. Review all incident reports, patient and physician questionnaires, monitoring and evaluation activities and any other activities deemed appropriate for QAPI review. 3. Report results of QAPI activities to the Professional Advisory Committee, Administrator and field personnel through written reports and staff meetings.4. Maintain all data regarding QAPI in a confidential manner and ensure the absence of individual patient identification reports.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BLESSED HANDS HOME CARE AGENCY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3221 S MICHIGAN STREET SOUTH BEND, IN 46614
--	---

(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>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on clinical record review, policy review, observation, and interview, the agency failed to ensure all durable medical equipment in the home was included on the plan of care for 1 of 7 active records reviewed (#1) and failed to ensure frequency of visits was included on the plan of care for 1 of 7 active patient records reviewed (#8).</p> <p>Findings include:</p> <p>1. Clinical record #1 contained a Home Health Certification and Plan of Care for certification period 3/15 to 5/15/15 that failed to list durable medical equipment in the home.</p> <p>A. On 5/15/15 at 10:40 AM at a home visit with patient #1, a cane, motorized wheel chair, and grab bars in</p>	N 524	<p>Administrator educated self on proper documentation on DME and equipment. Administrator to educate all new and incoming RN staff. To prevent re-occurrence Administrator will continue to re-educate staff on DME equipment documentation. Administrator to implement a DME Equipment checklist/audit tool to give to RN supervisory to complete during supervisory visits. Administrator will review charts monthly to ensure audit tool is being used correctly. Administrator wrote order for chart # 8, to clarify the plan of treatment.</p>	05/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2015	
NAME OF PROVIDER OR SUPPLIER BLESSED HANDS HOME CARE AGENCY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3221 S MICHIGAN STREET SOUTH BEND, IN 46614			
(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 bathroom next to the commode and in the shower were observed.</p> <p>B. On 5/15/15 at 11:25 AM, employee C (administrator-alternate director of nursing) indicated being unaware the equipment needed to be included on the plan of care because the patient had the equipment before admission and the equipment was not provided by the agency.</p> <p>2. Clinical record #8 contained a Home Health Certification and Plan of Care for certification period 9/14 to 11/12/14 that failed to include the skilled nurse visit frequency.</p> <p>A. The record evidenced a document dated 9/14/14 titled "Patient Case Conference" stating, "1 [one] SN [skilled nursing] visit q [every] 3 days to change dressing to nephrostomy site."</p> <p>B. On 5/14/15 at 12:15 PM, employee B (owner, office staff) indicated the skilled nursing visit was 1 time every 3 days and that frequency was not listed on the plan of care.</p> <p>3. The undated agency policy titled "Care Plan" states, "Development of Care Plan ... Steps to be taken in developing the care plan include: 1. Collection of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2015
NAME OF PROVIDER OR SUPPLIER BLESSED HANDS HOME CARE AGENCY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3221 S MICHIGAN STREET SOUTH BEND, IN 46614		
(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	
	baseline data including all pertinent diagnoses, including mental status, types of services, ... equipment required, frequency and duration of visits ... "				