PRINTED: 04/12/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		15K132	B. WING			02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE AG	GENCY LLC		4	STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 000	INITIAL COMMENTS		G	000			
		a Federal Home Health omplaints survey. The nded on 2/19/19.					
	Survey dates: 2/7/19	- 2/20/19					
	Complaint #: IN00271 substantiated. Federa complaint were cited.	765: Complaint was al deficiencies related to the					
	Complaint #: IN00254 substantiated. Federa complaint were cited.	1258: Complaint was al deficiencies related to the					
	Complaint #: IN00249 substantiated. Federa complaint were cited.	0387: Complaint was all deficiencies related to the					
	Complaint #: IN00246 substantiated. Federa complaint were cited.	8802: Complaint was al deficiencies related to the					
	Complaint #: IN00246 substantiated. Federa complaint were cited.	6088: Complaint was al deficiencies related to the					
	Complaint #: IN00240 substantiated. Federa complaint were cited.	al deficiencies related to the					
	Complaint #: IN00220 substantiated. Federa complaint were cited.	0665: Complaint was al deficiencies related to the					
	Facility ID: 013427						
	Provider #: 15K132						

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.

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		15K132	B. WING			02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		4	TREET ADDRESS, CITY, STATE, ZIP CODE 626 W WESTERN AVENUE COUTH BEND, IN 46619		
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G 000	Continued From page	e 1	G	000			
	Medicaid #: 2012701	20					
	year 11 home hea year 6 personal so year 16 Active pa	alth aide only patients in past ervice only patients in past tients d patients in past year					
G 372	from providing its own and competency eval of 2 years beginning beginning to 2, 2021. The systemic problem result of compliance with 484.60 Care planning and quality of care, 484.60 Care planning and performance import of compliance with 484.60 Care planning and quality of care, 484.60 Care planning and quality of care, 484.60 Care planning and performance import of services; 484.105 Oracle of services; 484.105 Oracle of services; and 484. Encoding and transmic CFR(s): 484.45(a)  Standard: An HHA medictronically transmit assessment to the CN beneficiary with respective of the complex of the beautiful of the beautiful of the complex of the beautiful of the complex of the beautiful of the complex of the	The cumulative effect of this ulted in the agency being the the 484.50 Patient Rights, a coordination of services, 84.65 Quality assessment rovement; 484.70 Infection of; 484.80 Home health aide anization and administration 110 Clinical records. itting OASIS  ust encode and the each completed OASIS of System, regarding each each to which information is itted (as determined by the days of completing the	G	372			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED		
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G 372	Based on agency of State Department of review, the agency had been transmitted completing an assess records reviewed (a received skilled ser comprehensive asservice over 60 days. The findings included 1. The agency documents assessment Inform Guidance Manual Estated, "OASIS Date HHA's are required submit OASIS dated date the assessments for clic completed 5/18/18, transmitted on 11/2 Agency documents Report OASIS Agedated 11/28/18 evicassessments comp 9/17/18 were submited on 11/2 Agency documents assessment had be 7/13/18, 9/11/18 for transmitted on 11/2 Agency documents Report OASIS Agedated 11/28/18 evicassessment had be 7/13/18, 9/11/18 for transmitted on 11/2 Agency documents Report OASIS Age	document review and Indiana of Health (ISDH) document failed to ensure OASIS data ed within 30 days of essment in 4 of 4 clinical #1, #2, #3, #4) of patients that vices and required sessments and had been on /s.  e:  cument titled "Outcome and hation Set OASIS C-2 Effective January 1, 2018, ta Encoding and Transmission: to encode and electronically to CMS within 30 days of the nt was completed."  se evidenced Recertification finical record #1 were 1,7/20/18, and 9/17/18 and 1,7/18.  citiled "CMS Submission finey Final Validation Report" denced Recertification foleted on 5/18/18, 7/20/18, and hitted on 11/27/18 to CMS.  se evidenced Recertification foleted on 5/18/18, 7/20/18, and hitted on 11/27/18 to CMS.	G 3	72			

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G 372	assessments complete 9/11/18 were submitted 4. ISDH documents of assessments for clinic completed 5/25/18, 7/4 transmitted on 11/28/18 Agency documents tiff Report OASIS Agency dated 11/28/18 evider assessments complete 9/25/18 were submitted 5. ISDH documents assessment for clinical was submitted on 11/2 assessments dated 7/17/17 was submitted Agency documents tiff Report OASIS Agency dated 12/3/18 evident 5/7/18 and Recertification 9/5/18 transmitted on Agency documents tiff Report OASIS Agency dated 11/28/18 evident transaction dated 5/7/11/28/18.  Agency documents tiff Report OASIS Agency documents tiff Report OASIS Agency dated 11/28/18 evident transaction dated 5/7/11/28/18.	ted on 5/11/18, 7/13/18, and ed on 11/28/18.  evidenced Recertification cal record #3 were (26/18, and 9/25/18 and 18.  fled "CMS Submission y Final Validation Report" need Recertification ted on 5/25/18, 7/26/18, and ed on 11/28/18 to CMS.  evidenced a start of care al record #4 dated 5/7/18 (28/18. Recertification /6/18, 9/5/18, 10/31/18 were 8. A discharge oasis dated 11/28/18.  fled "CMS Submission y Final Validation Report" ced a start of care dated ation assessment dated 12/3/18.  fled "CMS Submission y Final Validation Report" need a new record (18 and transmitted on 18 (18 and transmitted on 18 (18 and Validation Report) of the color of th	G 3				
O 700	i audit rights						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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G 406	right to be informed of language and manned. The HHA must protect of these rights. This CONDITION is a Based on record reviagency failed to ensure representatives receive administrator's name order for the administ (See G414); failed to adhered to by failing the complaints made by a to ensure the patient changes to the care to failed to ensure patient and that a patient recorder and treatment (See G414) patient representatives and treatment (See G414); failed to ensure their popatient of an impendiated to ensure they imade by the patient (ensure they document	tion: Patient rights. sentative (if any), have the f the patient's rights in a r the individual understands. It and promote the exercise not met as evidenced by: ew and interview, the re the patients/ patient yed the home health agency and contact information in rator to receive complaints ensure patient rights were to accept and process a patient (See G432); failed	G	406			
G 414	resulted in the home ensure the provision of safe environment for 484.50 Patient Rights		G.	414	l-		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X3) DATE SURVEY COMPLETED			
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G 414	including the admin address, and busing receive complaints. This ELEMENT is a Based on record reagency failed to ensure representatives receadministrator's namorder for the administrator's namorder for the administrator's namorder for the administrator's namorder for the administrator's namorder for the administrator will be adm	cion for the HHA administrator, istrator's name, business ess phone number in order to not met as evidenced by: eview and interview, the sure the patients/ patient eived the home health agency e and contact information in strator to receive complaints ords reviewed (#1 - 4, #6, #9, es:  by policy dated 2018 stated, vised at the time of admission cation about their rights and arding the receipt of home  ated Home Care Admission where the administrator's name or the name. This was presented to a contained the Patient Bill of which stated, "To be advised on for the agency's aline and no name here] with address of agency listed.  M, the office manager packet was given to the	G 41	4			
	A review of clinical i	ecord #1 with a start of care					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED		
		15K132	B. WING _			02/20/2019	
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC	•	STREET ADDRESS, CITY, STATE, ZIP CO 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 414	representative receadministrator's name complaints.  A review of clinical on 11/16/17 failed to representative receadministrator's in or 2/5/16 failed to representative receadministrator's name complaints.  A review of clinical on 11/18/15 failed representative receadministrator's name complaints.  A review of clinical on 11/18/15 failed representative receadministrator's name complaints.  A review of clinical 8/10/17 failed to en representative receadministrator's name complaints.	ge 6 ensure the patient/ patient ived the home health agency are in order to receive  record #2 with a start of care of ensure the patient/ patient ived the home health agency arder to receive complaints.  record #3 with a start of care ensure the patient/ patient ived the home health agency are in order to receive  record #4 with a start of care to ensure the patient/ patient ived the home health agency are in order to receive  record #6 with a start date of sure the patient/ patient ived the home health agency are in order to receive  record #6 with a start date of sure the patient/ patient ived the home health agency are in order to receive	G 4	.14			
	date of 11/10/18 fai patient representati agency's administra complaints.	led to ensure the patient/ ve received the home health ator's name in order to receive record #10 with a start of care ed to ensure the patient/					
	patient representati	ve received the home health ator's name in order to receive					

I ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K132	B. WING			02/:	20/2019	
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		46	TREET ADDRESS, CITY, STATE, ZIP CODE 326 W WESTERN AVENUE OUTH BEND, IN 46619			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
G 414	Continued From page	e 7 n 2/7/19 at 11:20 AM, the	G.	414				
	_	he owner indicated that strator or alternate						
0.422	clinical supervisor ind administrator and alte			422				
G 432	Make complaints to the CFR(s): 484.50(c)(3)	е нна	G ·	432				
	or care that is (or fails lack of respect for pro anyone who is furnish HHA;	ne HHA regarding treatment is to be) furnished, and the operty and/or person by ning services on behalf of the						
	Based on record revi agency failed to ensu adhered to by failing to complaints made by a	at met as evidenced by:  The wand interview, the  The patient rights were  The accept and process  The patient for 1 of 1 active  The patient for 5 ound with a						
	complaint.  The findings include:							
	Responsibilities" date be advised at the time Recertification about	ed "Patient Rights and d 2018 stated, "Patient will e of admission and at every their rights and ding the receipt of home						
	Procedure" dated 201 and concerns are to b	ed "Patient Grievance 18 stated, "All grievances be dealt with by the her designee. When a						

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G 432	is to be documented record by the administrator. It is also to be noted administrator. 4. The also to be documented Each written grievand responded to in writing days."  The agency documer Rights" dated 2018 stight to voice grieval care that is [or fails to who is furnishing servagency, or recommend or service/ care without coercion, discriminating that grievances will be notified of the resolut.  The agency document dated 2018 stated, "Nate important to the acconsideration to a promake an effort to reseagreeable manner. We have the opportunity recommend changes without discrimination unreasonable interrup manner from the age ask questions or lodg agency with the Comprogram "  A review of clinical research administrator of clinical research.	whether written or verbal, it in the patient's clinical strator or his / her designee. In a log kept by the eresolution of the problem is ed in the same manner. It is received is to be ag by the agency within 10 and titled "Patient Bill of tated, "The patient has the ances regarding treatment or to be furnished] by anyone vices on behalf of the ands changes in policy, staff, but restraint, interference, on or reprisal and to know the resolved and the patient ion within 30 days."  Intitled "Patient Grievance" Your complaints or problems agency. We will give full oblem or a complaint and	G	432				
		plaint was investigated. This						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	AGENCY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619				
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G 432	Report" dated 12/20 H, RN, stated, "Patic regards to staffing. [ made up, that [he/ s schedules are chang ongoing and there h Nurse to report to of Personal Service At [he/ she] prefers to h report form was che satisfied with the can A review of the come evidence a complair regards to the comp During an interview owner did not indica a complaint investig report dated 12/20/1  During a phone inter patient #10 indicated of Employee P, Hon that Employee P did problems with the st patient indicated Em personal care was p  During an interview 4:30 PM, the owner Employee T, placed spot." This complair complaint log.	ed by the following:  Jument titled "Supervisory Visit /18 and signed by Employee ent voices concerns in Patient] states hours don't get he] is not notified if aides ged. [He/ she] states this is asn't been much rectified. If it is not reliable, and have other people." The cked that the patient was not re.  Plaint log on 2/14/18 failed to not made by patient #10 in laint made on 12/20/18.  On 2/14/19 at 4:30 PM, the te agreement with the lack of ation for the Supervisory Visit 8.  Prview on 2/15/19 at 9:40 AM, dissatisfaction with the care ne Health Aide. She indicated and this caused aff running errands. The uployee P did clean but no	G 432				

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	ROVIDER OR SUPPLIER  HANDS HOME CARE A	AGENCY LLC		4626 W W	DDRESS, CITY, STATE, ZIP CODE VESTERN AVENUE BEND, IN 46619			
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G 432	not to call anymore to care received anymore staff would watch TV were at her house.	te 10 If the office manager told her to complain about the lack of the Patient #10 indicated for the time when they		132				
G 434	refuse care in advant where appropriate, work (i) Completion of all a comprehensive assets (iii) The care to be further comprehensive assets (iii) Establishing and (iv) The disciplines the (v) The frequency of (vi) Expected outcompatient-identified goal benefits; (vii) Any factors that effectiveness; and (viii) Any changes in This ELEMENT is not Based on record revagency failed to ensurabout changes to the 4 active skilled clinic #4).  The findings include:  1. The agency policinos of Charming when it is anticipated.	ormed about, and consent or ce of and during treatment, with respect to assessments; rnished, based on the essment; revising the plan of care; nat will furnish the care; visits; nes of care, including als, and anticipated risks and could impact treatment the care to be furnished. ot met as evidenced by: view and interview, the ure patients were informed e care to be furnished for 2 of al records reviewed (#1 and	G	134				
		notify the office. a. The designee will contact the						

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(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 434	care staff member accordance with the patient the option documentation reciplaced in the patient.  2. The agency do Rights" dated 201 right to be fully information in a conderstand these time 2. To receive discrimination in a orders."  3. On 2/13/19 at indicated patient # scheduled skilled the clinical manage the weather. This nurse visit every for a bowel prograte to make the visit to date).  A review of the clinevidenced a plan operiod of 1/17/19 evidenced the folkinterventions: Ass PCG [patient/ patimus Bisacodyl [Dulc Suppository Rectar Wednesday, Fridates]	them that an alternate direct will be conducting their visit in the plan of care or give the to reschedule the visit C. All garding the missed visit will be	G	434		

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G 434	PM, patient #1 indic was canceled this melvel of 6 in the left aconstipation and lace scheduled. Patient would make a visit to program. Patient #1 not understand how well being and comf program as schedul missed visit with his happened before. For communication was staff and office staff.  During a phone call PM, Employee H, Roreschedule the bowe about noon and that the visit that day due commitment. She would with the patient for 24. A review of an aid dated 1/3/19 and sig stated, "Pt states aid when they come. [Hobeen a few days [she] the/ she] states staff but [he/ she] states staff but [he/ she] states staff but [he/ she] wishes changes."  Receive all services This ELEMENT is rescribed.	interview on 2/13/19 at 2:28 cated the skilled nurse visit forning and having a pain abdominal area due to k of the bowel program as #1 indicated another nurse he next day for the bowel indicated the office staff did important it was for his/ her fort to have the bowel ed. Patient #1 indicated this // her bowel program had patient #1 indicated lacking between the field interview on 2/15/19 at 12:35 N, indicated being called to ell program for patient #1 she was unable to complete et to having another was able to schedule this visit //14/19.  Ide supervisory visit report year able to schedule this visit with year of care) the she] stated there have et he] has had no service." If is friendly and professional office would communicate	G 43			

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G 436	Continued From page 13		G 4	136				
	adhered to and that	ure patient rights were a patient received consistent atment for 1 of 4 active wed (#1).						
	The findings include:							
	"When it is anticipated because of an unfore staff will immediately director of nursing or patient and notify the care staff member waccordance with the patient the option to	ages" dated 2018 stated, and a visit cannot be made eseen situation, the agency ontify the office. a. The designee will contact the em that an alternate direct ill be conducting their visit in plan of care or give the reschedule the visit C. All ding the missed visit will be						
	Rights" dated 2018 s right to be fully inform knowledgeable of all before providing pre- understand these rig time 2. To receive ap	rights and responsibilities						
	the director of nursin the weather. This p nurse visit every Mor for a bowel program.							

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	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		4	TREET ADDRESS, CITY, STATE, ZIP CODE 626 W WESTERN AVENUE COUTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 436	PM, patient #1 indica was canceled this modevel of 6 in the left all constipation and lack scheduled. Patient # would make a visit or program. Patient #1 not understand how i well being and comfor program as scheduled missed visits with his happened before. Pacommunication was I staff and office staff.  A review of the clinical evidenced a plan of comperiod of 1/17/19 - 3/1 evidenced the followinterventions: Asses	nterview on 2/13/19 at 2:28 ated the skilled nurse visit orning and having a pain bedominal area due to the of the bowel program as at indicated another nurse in 2/14/19 for the bowel indicated the office staff did indicated the office staff did indicated the office staff did indicated the bowel d. Patient #1 indicated / her bowel program had atient #1 indicated acking between the field all record #1 on 2/14/19 care for the certification 17/19. This plan of careing: "SN Gastrointestinals / Perform/ Instruct Pt /	G	436			
G 462	Bisacodyl [Dulcola Suppository Rectal S Wednesday, Friday]: patient had signed th care on 2/2/16.  During a phone call in PM, Employee H, RN reschedule the bowe about noon and that the visit that day due	uppository M, W, F [Monday, start date 1/16/19." The e patient rights at the start of enterview on 2/15/19 at 12:35 I, indicated being called to I program for patient #1 she was unable to complete to having another yee H was able to schedule ent for 2/14/19. cause HHA must:	G	462			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		15K132	B. WING _		02/20/2019
	ROVIDER OR SUPPLIER	E AGENCY LLC		STREET ADDRESS, CITY, STATE, Z 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	•
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE
G 462	Continued From p	age 15	G 4	462	
	HHA for the purpo cause that meets to (d)(5)(i) through (d) patient's (or other behavior is disrupt to the extent that of the ability of the H seriously impaired following before it This ELEMENT is Based on record agency failed to en and documentation representative being impending dischar records of a skilled. The findings include The agency policy Policy dated 2018 the discharge [final receive the discharge [final receive the discharge [final receive the form to sign the notice of [NOMNC] "  A review of the cloevidenced a start on 10/25/18. This patient was not give what was used by the patient/ patient used was called a Notice and was not given to the start of the patient of the p	titled "Discharge/ Transfer stated, "At least 15 days before I] visit the patient/ client will rge with instructions on the m. The patient will be required of Medicare Noncoverage  sed record for clinical record #5 of care 7/25/18 and discharge record evidenced that the ven a discharge notice since the agency was not signed by a representative. The form Home Health Change of Care of signed by the patient or tive. It was unknown when the			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K132	B. WING			02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC	•	4	TREET ADDRESS, CITY, STATE, ZIP CODE 626 W WESTERN AVENUE OUTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 462	Continued From page	e 16	G	462			
G 480	office manager indica occurred because of	in 2/18/19 at 12:30 PM, the steed patient #5's discharge the threatening calls from ntative. A discharge notice	G	480			
	(i)(A) Treatment or ca furnished, is furnished furnished inappropria This ELEMENT is no Based on record rev agency failed to ensu complaint made by the	are that is (or fails to be) d inconsistently, or is					
	The findings include:						
	Rights" dated 2018 stright to voice grieval care that is [or fails to who is furnishing servagency, or recommer or service/ care without coercion, discriminati	nds changes in policy, staff, out restraint, interference, on or reprisal and to know e resolved and the patient					
	dated 2018 stated, "Yare important to the a consideration to a promake an effort to reso	nt titled "Patient Grievance"  Your complaints or problems agency. We will give full bblem or a complaint and blve the issue in an  We assure you that you will					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15K132	B. WING			02/	20/2019	
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC	Ì	46	REET ADDRESS, CITY, STATE, ZIP CODE 26 W WESTERN AVENUE DUTH BEND, IN 46619			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
G 480		to voice grievances and	G 4	180				
	recommend changes without discrimination unreasonable interru manner from the age ask questions or lodg	in services and/ or policies n, coercion, reprisal, or potion of services or in any ncy You may also call to be complaints about the munity Health Accreditation						
	on 11/16/17 failed to	cord #10 with a start of care ensure the patient/ patient plaint was investigated. This d by the following:						
	Report" dated 12/20/ H, RN, stated, "Patie regards to staffing. [F made up, that [he/ sh schedules are chang ongoing and there ha Nurse to report to off Personal Service Atte [he/ she] prefers to ha	Patient] states hours don't get e] is not notified if aides ed. [He/ she] states this is isn't been much rectified. ice states [Employee R, endant] is not reliable, and ave other people." The ked that the patient was not						
	evidence a complaint	laint log on 2/14/18 failed to made by patient #10 in aint made on 12/20/18.						
	owner did not indicate	on 2/14/19 at 4:30 PM, the e agreement with the lack of tion for the Supervisory Visit 3.						
	patient #10 indicated	view on 2/15/19 at 9:40 AM, dissatisfaction with the care e Health Aide. She indicated						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K132	B. WING			02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		4	TREET ADDRESS, CITY, STATE, ZIP CODE 626 W WESTERN AVENUE COUTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 480	problems with the state patient indicated Empresonal care was problems of the personal care was problems. During an interview of 4:30 PM, the owner in Employee T, placed the spot." This complaint complaint log.  During a phone intervipatient #10 indicated not to call anymore to care received. Patient	not drive and this caused ff running errands. The ployee P did clean but no ovided.  In 2/15/19 at approximately indicated the office staff, his complaint in the "wrong was not placed in the riew on 2/18/19 at 9:30 AM, the office manager told her o complain about the lack of at #10 indicated staff would of time when they were at her		480			
	CFR(s): 484.50(e)(1)(ii) Document both the and the resolution of This ELEMENT is not Based on record reviagency failed to ensure existence and resolution the patient for 1 of 1 at (#10) of a record four The findings include:  The agency policy title Procedure" dated 20° and concerns are to be administrator or his / grievance is received is to be documented.	e existence of the complaint the complaint; and the complaint; and the transport of the existence of the complaint; and the transport of the existence of the complaint of the existence of the complaint of the existence of the complaint.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONS	STRUCTION	(X3) DATE	SURVEY
		15K132	B. WING _			02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC	•	4626 W	ADDRESS, CITY, STATE, ZIP CODE WESTERN AVENUE H BEND, IN 46619	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
G 484	also to be document. Each written grievan responded to in writin days."  The agency docume Rights" dated 2018 sright to voice griev care that is [or fails to who is furnishing ser agency, or recomme or service/ care with coercion, discriminate that grievances will be notified of the resolution of the resolution to a promake an effort to resugreeable manner. In have the opportunity recommend changes without discrimination unreasonable interrumanner from the age ask questions or lodg agency with the Comprogram "  A review of clinical reconsiderative's common was further evidences."	in a log kept by the e resolution of the problem is ed in the same manner. ce received is to be ng by the agency within 10  Int titled "Patient Bill of stated, "The patient has the rances regarding treatment or to be furnished] by anyone vices on behalf of the nds changes in policy, staff, out restraint, interference, ion or reprisal and to know the resolved and the patient tion within 30 days."  Int titled "Patient Grievance" Your complaints or problems agency. We will give full oblem or a complaint and olve the issue in an We assure you that you will to voice grievances and s in services and/ or policies n, coercion, reprisal, or ption of services or in any ency You may also call to ge complaints about the munity Health Accreditation  accord #10 with a start of care ensure the patient/ patient plaint was investigated. This	G 4	.84			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		15K132	B. WING			02/:	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	<u>:</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) COMPLETION DATE
G 484	H, RN, stated, "Patier regards to staffing. [Fmade up, that [he/sh schedules are change ongoing and there had Nurse to report to offi Personal Service Atteres [he/she] prefers to have report form was chect satisfied with the care. A review of the complevidence a complaint regards to the complevidence a complaint regards to the complex of the complex	and signed by Employee int voices concerns in vatient] states hours don't get e] is not notified if aides ed. [He/ she] states this is is in the been much rectified. It is not reliable, and ave other people." The ked that the patient was not example in the patient was not example in the patient #10 in aint made on 12/20/18.  In 2/14/19 at 4:30 PM, the exagreement with the lack of tion for the Supervisory Visit in a complaint in the "wrong it was not placed in the it medications.  In aint the patient is currently the tions, including ineffective ant side effects, significant olicate drug therapy, and		536			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		(X3) DATE SU COMPLE	
		15K132	B. WING _			02/20	/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	AGENCY LLC		STREET ADDRESS, CITY, STAT 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	( (EACH CORRECT) CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)	-	(X5) COMPLETION DATE
G 536	were updated and co active skilled patient: reviewed (Patient #4 The findings include: The agency policy tit dated 2018 stated, " have a current list of comprehensive asse all medications the p prescription and non medication list is coll clinical record. The the patient/ client's c and additions and/ o identified in clinical On 2/13/18 at 1 PM, presented the most if found in the clinical r period of 11/4/18 - 1/2 Employee H, Registe	crrectly documented for 1 of 4 is whose clinical records were in the second sec	G		TOLENOT)		
	ml (milliliter) 30 units bedtime for indication teaching performed administration.  A review of a packet patient #4's incenter 2/18/19 evidenced a was last reviewed by on the list, was Insulbedtime. The start of entered date of 1/21.  During an interviewed	of information received from hemodialysis clinic dated home medication list that an RN on 2/11/19. Included in Glargine inject 20 units at late was 12/21/18, with an					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION  IG	1, ,	(X3) DATE SURVEY COMPLETED		
		15K132	B. WING _			02/20/2019		
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC	,	STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	·			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
G 536	Continued From pa	ge 22	G 5	336				
	medication profile w date.	vas not accurate and up - to -						
G 544	Update of the comp CFR(s): 484.55(d)	orehensive assessment	G 5	544				
	assessment. The comprehensive updated and revise of the OASIS) as frecondition warrants of improvement in the less frequently than This STANDARD is Based on record reagency failed to enseconsistently and acceptance.	s not met as evidenced by: eview and interview, the sure the Registered Nurse curately reassessed the 2 of 4 active skilled records						
	Nursing Service" da services are provide Professional Nurse teaches and superv patient care, is resp needs and for plans with professional st each patient/ family following nursing fu Initial and ongoing a needs, including Ou information set [OA appropriate time po ensure that the pati	cy titled "2.6 Service Policies ated 2018 stated, "Nursing ed by Registered Nurses the RN gives direct care, vises others in aspects of ponsible for assessing patient ning patient care In keeping andards and depending upon or need, all or a selection of the nctions may be performed: a. assessments of the patient's utcome and assessment SIS] assessments at ints Reassessment To ent/ client's current problems inuously evaluated and the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		15K132	B. WING			02/20/2019		
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP COD 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	•			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
G 544	patient's / client's st The reassessment   the patient/ client's teach patient/ client's the patient/ client's Reassessment occupatient/ client is reconstructed in the patient/ client is reconstructed in the recertification reaches the recertification reaches the recertification including OASIS Eleast Information, dailed to show a suprapublic catheter. Under M 1610 on the checked that the pacatheter. Under this not documented as color of urine, clarity date last changed, a signed by Employee 3. A review of Clinical 1/18/15, failed to each the recertification reaches the recertificati	usted accordingly, the atus is reviewed periodically. Process is ongoing throughout contact through the agency. It is reassessed to determine response to care or services. Process. It is used in the action of the	G 54	14				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K132	B. WING _			02/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		STREET ADDRESS, CITY, STATE, ZIP C 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 544	blood pressure in this pressure was noted at There was no documpatient receiving hem an in-center hemodia. A review of a packet opatient #4's in-center 2/18/19, contained that the patient's hemodia at a nearby in-center. A review of the patient in-center hemodialysis Transfer: Care Trans 2/18/19 first date opatient receives chrothemodialysis access. Above Elbow / Brachi Please consider the f No BP [Blood Presaccess arm; no blood hemodialysis cathete KG [gram / kilogram] daily supplements, 2 salt, limit to 1 serving [cubic centimeters] flus supplements, no conchigh protein renal supplements	a right arm. The blood as 165/84 in the right arm. entation concerning the odialysis 3 times a week at lysis center.  of information received from hemodialysis clinic dated e following information about lysis treatment and orders hemodialysis center.  at's current status at the scenter stated, "Patient itions report Current date if dialysis 7/26/16 This nic dialysis and a vascular AV Fistula Standard / iocephalic - Right [Active] collowing for admitting orders sure], blood draws, or IVs in draws or IV lines in r Dietary order 1.2 GM / 1.2 GM / KG protein plus GM potassium, no added dairy per day, 1500 cc aid limit including centrated sweets if diabetes, oplements 2 times a day"  n 2/16/19 at 12:50 PM, red Nurse, indicated record and the assessment failed to cout the patient's right arm sis treatments.	G 5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K132	B. WING _			2/20/2019	
	ROVIDER OR SUPPLIER HANDS HOME CAR	E AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CO 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	•		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 570	coordination of se Patients are accel reasonable expect patient's medical, social needs in his Each patient must written plan of car additions. The ind specify the care a the patient-specific comprehensive as identification of the measurable of anticipates will oc and coordinating findividualized plar patient and caregistervices must be accepted standard. This CONDITION Based on observinterview, the age medical and nursi place of residence reviewed with the and effective care failed to ensure short provordered plan of care was not provordered plan of care skilled nurse promothanges in the pafailed to ensure the patients are accepted as a patient and patients are accepted as a pati	cipation: Care planning, rvices, and quality of care. pted for treatment on the tation that an HHA can meet the nursing, rehabilitative, and so or her place of residence. It receive an individualized re, including any revisions or ividualized plan of care must and services necessary to meet conceds as identified in the responsible discipline(s), and automes that the HHA cur as a result of implementing the plan of care. The nof care must also specify the reducation and training.	G 5	70			
		home health aide visits to be ledications, fluid restrictions, all					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K132	B. WING		02/20/2019	
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC	4	TREET ADDRESS, CITY, STATE, ZIP CODE 626 W WESTERN AVENUE COUTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
G 570	(see G 592); failed new orders with the physician after a pa hospital (see G 602 nursing and home hamongst each other ensure they coording the patient's dialysis failed to ensure the contact information patients (see G 622). The cumulative efferesulted in the homensure the provision safe environment for 484.60 Care Planni Care.  In regards to G570,  1. The agency policy Acceptance of Patier "Acceptance of Indicare services is base expectation that the and social needs wistaff members visit residence."  2. On 2/13/19 at 11 indicated patient #1 scheduled skilled not the director of nursi the weather. This nurse visit every Moron a bowel program	ill durable medical equipment to ensure they communicated patient's primary care tient was discharged from the communicated to ensure skilled to ensure skilled to eated care and services with secenter (see G 608); and clinical manager's name and was provided to 7 of 7 active	G 570			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		15K132	B. WING		02/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC	4	STREET ADDRESS, CITY, STATE, ZIP CODE 1626 W WESTERN AVENUE SOUTH BEND, IN 46619	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
G 570	PM, patient #1 indice was canceled this management was canceled this management would make a visit of program. Patient #1 not understand how well being and comforgram as schedule missed visits with his happened before. From the communication was staff and office staff.  A review of the clinical evidenced a plan of period of 1/17/19 - 3 evidenced the follow interventions: Assest PCG [patient / patient Bisacodyl [Dulcola Suppository Rectal Start Wednesday, Friday] patient had signed the care on 2/2/16.  During a phone call PM, Employee H, Rireschedule the bower about noon and that the visit that day due commitment. Emplot this visit with the patient was cared as a commitment.	interview on 2/13/19 at 2:28 sated the skilled nurse visit orning and having a pain abdominal area due to the k of the bowel program as #1 indicated another nurse in 2/14/19 for the bowel indicated the office staff did important it was for his/ her ort to have the bowel ed. Patient #1 indicated sher bowel program had ratient #1 indicated lacking between the field stal record #1 on 2/14/19 care for the certification /17/19. This plan of care ring: "SN Gastrointestinal is / Perform/ Instruct Pt / Int caregiver]: Bowel Program ax 10 mg [milligram] Suppository M, W, F [Monday, start date 1/16/19." The ne patient rights at the start of interview on 2/15/19 at 12:35 N, indicated being called to el program for patient #1 she was unable to complete et to having another oyee H was able to schedule	G 570		

PRINTED: 04/12/2019 FORM APPROVED OMB NO. 0938-0391

<u> </u>	C . C. C. III. EDIO/ II L G	WEDIO/ ND OEI (VIOLO				C.11.D 11C	7. 0000 000 I	
I ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		15K132	B. WING			02/	20/2019	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
BLESSED	HANDS HOME CARE A	GENCY LLC			626 W WESTERN AVENUE OUTH BEND, IN 46619			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
G 570	dated 2/18/18 - 3/2/1 document and dischare evidenced the patien added to the medical discharge summary opatient had a dischar Diabetes Mellitus wit manifestations, unco controlled by diet but and possibly adjustm Discharged on Lantu subcutaneous nightly Monitoring, adult Moralso known as blood your diabetes. It also care provider monitor determine how well y working When sho care provider will help should check your blidepend on the type of diabetes control, or that taking. Be sure to will glucose readings so reviewed with your help working in the late of the alth care provider Diabetes It can vary generally if you are on How to monitor you needed Blood glucose pricking needle [lancelancet, a journal or location of the street of the patients of the	ization discharge document 8 from an emergency room arge report summary thad long-acting insulination regimen on 3/1/18. The dated 3/2/18 evidenced the rege diagnosis of " Type 2 the neurological and renal introlled; previously now needing basal insulinations as outpatient s [insulin glargine] 30 units of Blood Glucose intoring your blood glucose [ sugar] helps you to manage to helps you and your health or your diabetes and four treatment plan is fould you test? Your health or you decide how often you good glucose. This may be diabetes you have, your the type of medicines you are rite down all of your blood that this information can be realth care provider. See of testing times that your may suggest Type 2 with each person, but on insulin, test 4 times a day our blood glucose Supplies are meter, test strips, a ret], a device that holds the glook to write down your idea to keep a daily record	G	570	DEFICIENCY)			
	A review of a Plan of	Care dated 11/4/18 - 1/2/19						

failed to show the blood sugars would be checked

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	PLE CONSTRUCTION IG	(2	(X3) DATE SURVEY COMPLETED	
		15K132	B. WING _			02/20/2019	
	ROVIDER OR SUPPLIER  HANDS HOME CARI	E AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP COE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	)E		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT	(X5) COMPLETION DATE	
G 570	other testing supp Recertification of I patient should hav skilled nurse visits about what arm to the patient had a rin-center hemodia week. Insulin glar subcutaneous 30 under medications sugar is greater th deciliter) or less th Start 10/31/18. Un endocrine interver "Assess/ perform/ patient caregiver) and importance of effective date: 10/ evidenced the hor hours a day sever A review of the hor the certification periodenced missed health aide visits. day 7 days a weel 11/4/18, 11/10/18, 11/25/18, 11/26/18, 12/3/18, 12/5/18, 12/12/18, and 12/12/18, and 12/12/18, and 12/12/18, and 12/12/18, and 12/12/18 it (This with pressures and oth	lies available. The Patient Eligibility showed the re a diabetic foot examination at at. There were no precautions take blood pressures in or that right upper arm fistula for lysis treatment three times a gine 100 unit/ml (milliliter) units at bedtime was listed at a line 140 mg/dl (milligrams/lan 60 mg/dl fasting random. Inder SN (Skilled Nurse) Intions, this document stated, instruct pt/ pcg (patient / blood testing every [left blank] if recording and compliance. 31/18." This care plan the health aide was to visit 5 and days a week.  Independent of 11/4/18 - 1/2/19 visits for daily scheduled home The aide was to visit 5 hours a kar Missing visits were found on 11/19/18, 11/23/18, 11/24/18, 13, 11/28/18, 11/30/18, 12/1/18, 12/7/18, 12/8/18, 12/9/18, 13, 12/15/18 12/19/18, 12/21/18, 12/21/18, 12/15/18 12/19/18, 12/21/18, 12/21/18, 12/15/18 12/19/18, 12/21/18, 12/21/18, 12/15/18 12/19/18, 12/21/18, 12/21/18, 12/15/18 12/19/18, 12/21/18, 12/21/18, 12/15/18 12/19/18, 12/21/18, 12/21/18, 12/21/18, 12/21/18, 12/15/18 12/19/18, 12/21/18	G 5	70			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		15K132	B. WING _			02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 570	Continued From pag	ge 30	G t	570			
	1/3/19 and signed by states aides follow F come. [He/ she] stat days [she/ he] has he states staff is friendly she] wishes office where a review of a Recert assessment includin 485 information date Employee H evidence in the right arm and endocrine and hemal patient had Type 2 Elood sugar ranges monitored blood sugunder nutritional requiver adequate, hydration "Patient/ caregiver elected yes]." Nur diabetic observation DME supplies, Diabet A review of a plan of period of 1/3/19 - 3/3 to visit 1 hour a wee was to visit 5 hours all Interventions include the physician if bloom g/dl or less than 60 effective 1/4/19. Nur evidenced a diabetic renal diet. There was restrictions. Under 0 assess pt / pcg: die management of the	supervisory visit report dated y Employee H stated, "Pt POC (plan of care) when they ted there have been a few had no service." [He/ she] y and professional but [he/ ould communicate changes." iffication and follow up g OASIS elements and CMS ed 1/3/19 and completed by sed blood pressure was taken read 165/ 84. Under the stology section evidenced the Diabetes and required insulin. were left blank as was who hars. Assessment findings uirements showed intake adequate. The form stated, ducation Glucometer use sing interventions included the teach diabetic care. Under letic supplies were left blank.  If care for the certification 8/19 evidenced the nurse was k and the home health aide a week, 7 days a week. It is with a sign parameter notify diglucose is greater than 140 of mg/dl fasting random start tritional requirements and the diet in the complete states of the certification of fluid Gastrointestinal intervention: the hydration to promote proper disease process. Under cons. Assess/ Instruct on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(2	(X3) DATE SURVEY COMPLETED	
		15K132	<b>15K132</b> B. WING			02/20/2019	
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC	•	STREET ADDRESS, CITY, STATE, ZIP C 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	TION
G 570	hyperglycemia and blood glucose testi importance or recostin and diabetic for evidence of where pressure safely.  A review of a pack patient #4's in-cent on 2/18/19 contain about the patient's Standard/ above e [active] Please cor admitting orders access arm; no blo hemodialysis cather consider the follow [gram/ kilogram] processed for the follow [gram/ kilogr	age 31 , and symptoms of hypo/ d appropriate actions to take, on ing every [left blank] and ording and compliance, and oot care. There was no to take the patient's blood  et of information received from ter hemodialysis clinic received ed the following information current orders: "AV Fistula lbow/ brachiocephalic - Right hisider the following for No BP, blood draws, or IVs in ood draws or IV lines in eter dietary order [please ring diet order] 1.2 Gm/kg orderin plus daily supplements, 2 added salt, limit to 1 serving of cc [cubic centimeter] fluid olements, no concentrated Current outpatient nutrition of ml [milliliter] Start Date: Medical info: Home 6/19 last RN Review date at Aviva Plus Meter [Blood tient use daily start date and 1/21/19 Accucheck of [blood sugar diagnostic] times a day start date date 1/21/19 Accucheck soft at 3 times a day start date dated 1/21/19 Touji - solo star inject 20 units at bedtime "  d nursing visit notes dated /31/19, 2/8/19 completed by nood a blood pressure	G	570			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K132	B. WING		02/20/2019		
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC	4	STREET ADDRESS, CITY, STATE, ZIP CODE 1626 W WESTERN AVENUE SOUTH BEND, IN 46619			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION		
G 570	health aides encour 11/7/18, 11/12/18, 11/16/18, 11/17/18, 11/12/18, 11/12/18, 11/12/18, 11/12/18, 11/12/18, 12/10/18, 12/10/18, 12/10/18, 12/10/18, 12/10/19, 1/3/19, 1/4/1/8/19, 1/10/19, 1/11/22/19, 1/24/19, 1/24/19, 1/22/19, 1/24/19, 1/24/19, 1/22/19, 1/24/19, 1	it records evidenced the home raged fluids on 11/6/18, 11/13/18, 11/14/18, 11/15/18, 11/18/18, 11/18/18, 11/22/18, 12/2/18, 12/2/18, 12/4/18, 12/6/18, 12/13/18, 12/16/18, 12/17/18, 12/24/18, 12/25/18, 12/31/18, 19, 1/5/19, 1/6/19, 1/7/19, 5/19, 1/19/19, 1/20/19, 1/20/19 and 1/29/19.  on 2/13/19 at 11:15 AM, the see that missing visits had all record #4.  on 2/14/19 at 12:20 PM, hall Service Attendant, and as a home health aide. Seed patient #4 did not drink so they would encourage	G 570				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	•	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
G 570	patient.  During an interview owner indicated star glucometers but the own glucometers in During an interview owner indicated par glucometer in the hatheir blood sugars a facility may check to During a phone call Employee H indicat glucometer.  5. During an office 10:30 AM, the office speaking to patient which the office manager indinis/ her head with a patient had no concephysician had not be	fic fluid restrictions for this  on 2/15/19 at 4:15 PM, the ff nurses did not carry e patients were to have their the home.  on 2/15/19 at 5 PM, the tient #4 did not have a ome, the patient did not check at home, and that the dialysis ne patient's blood sugars.  on 2/20/19 at 3:35 PM, ed patient #4 did not have a  observation on 2/15/19 at e manager was heard #9's family on the phone in nager indicated the patient  on 2/15/19 at 11:10 AM, the cated patient #9 had bumped a recent fall at home, the terns with this fall, and the	G 57			
	Employee H, Regis #9 was not one of h During an interview office manager indi The office manager patient #9 since a fi	tered Nurse, indicated patient				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K132	B. WING			02/:	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE AG	GENCY LLC		46	TREET ADDRESS, CITY, STATE, ZIP CODE 626 W WESTERN AVENUE OUTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 570	Continued From page		G t	570			
G 572	patient's representation. The patient represent had fallen and bumper the head disappeared was fine. The patient Emergency Medical Finduse and transport to declined.  During an interview of Employee H indicated patient for he/ she was agency to not visit par Plan of care CFR(s): 484.60(a)(1)  Each patient must red services that are writt of care that identifies outcomes and goals, periodically reviewed, medicine, osteopathy scope of his or her staregistration. If a physiplan of care that cannon an evaluation visit, the approve additions or in plan.  This STANDARD is in Based on record reviagency failed to ensu bowel program per th patient record review program, failed to ensu absent of a physician-	d she did not go see the s told by the owner of the tient #9 after the fall.	G s	572			

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG	(X3	(X3) DATE SURVEY COMPLETED	
		15K132	B. WING _			02/20/2019	
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CO 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 572	health aide and skill the plan of care for oreviewed (#1, #2, #3). The findings include 1. The agency polic Provided," dated 20 / Licensed Practical Nurses [RNs] proviousit or the shift. The follow the physician's the patient regarding 2. The agency polic Services," dated 20 involved in the patien coordinating care of objectives outlined is "  3. A review of clinic that the patient's bornurse visit schedule Wednesday, Friday 2/13/19.  On 2/13/19 at 11 AN indicated patient #1 scheduled skilled not the director of nursing the weather. This process is to every Moror a bowel program.	ed nursing provided visits per 6 of 12 clinical records 8, #4, #7, #9 ).  Expect titled "2.3 Services 18 stated, "Registered Nurses Nurses: 1. Registered le quality nursing care by the e highly trained professionals is orders, monitor, and instruct gotheir care."  Expect titled "2.36 Coordination of 18 stated, "All personnel int's care are responsible for fectively to support the in the patient's plan of care  all record #1 failed to show well program and a skilled do for every Monday, occurred on Wednesday,  M, the office manager	G 5	572			
		cal record #1 on 2/7/19 and a plan of care for the					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  IG		ATE SURVEY DMPLETED
		15K132	B. WING _			02/20/2019
	ROVIDER OR SUPPLIER	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CO 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 572	of care evidenced the Gastrointestinal interpretation of Care evidenced the Gastrointestinal interpretation of Care evidenced the Instruct Pt / PCG [pt Bowel Program Emilligram] Supposit F [Monday, Wednesd 1/16/19."  During a phone call PM, patient #1 indice was canceled this melevel of 6 in the left acconstipation and lad scheduled. Patient would make a visit of program. Patient #1 not understand how well being and comprogram as schedul missed visit with his happened before. From the communication was staff and office staff.  4. A review of an author of the care of the c	of 1/17/19 - 3/17/19. This plan the following: "SN preventions: Assess / Perform/satient / patient caregiver]: Bisacodyl [Dulcolax] 10 mg tory Rectal Suppository M, W, aday, Friday] start date  interview on 2/13/19 at 2:28 cated the skilled nurse visit forning and having a pain abdominal area due to took of the bowel program as #1 indicated another nurse on 2/14/19 for the bowel indicated the office staff did important it was for his/her fort to have the bowel thed. Patient #1 indicated a lacking between the field	G 5	72		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE	SURVEY PLETED
		15K132	B. WING			02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		4620	EET ADDRESS, CITY, STATE, ZIP CODE 6 W WESTERN AVENUE UTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 572	evidenced the aide v 1/12/19, 1/13/19, 1/1 1/18/19, 1/19/19, 1/2 1/29/19, 1/31/19, 2/2 2/6/19, 2/7/19, 2/8/19 2/12/19. The skilled  5. A review of record evidenced the plan of period of 1/24/19 - 3/2 saved on 2/7/19 and 2/7/19. The plan of timely manner and caplan of care being cophysician for approvation evidenced by the following of the certification period evidence any frequent in the plan of care evidence any frequent interventions which in the plan of care evidence and the pla	d on 2/14/19 and 2/20/19 isited on 1/10/19, 1/11/9, 4/19, 1/15/19, 1/16/19, 4/19, 1/25/19, 1/27/19, /19, 2/3/19, 2/4/19, 2/5/19, 0, 2/9/19, 2/10/19, 2/11/19, nurse only visited on 2/6/19.  I #3 on 2/8/19 and 2/15/19 of care for the certification 24/19 was created and faxed to the physician on care was not completed in a are took place without the impleted and sent to the al. This was further owing:  an of care" dated 2/7/19 for d of 1/24/19 - 3/4/19 failed to ncy and duration for skilled Ith aides services. However, enced skilled nurse included neurological, estinal, genitourinary, regumentary, pain is the patient's neurological ealth aide interventions were ent titled "Aide Care Plan" inced the aide was to visit 8 is week and the skilled nurse	G	572			
	visits were completed	d evidenced skilled nurse d on 1/29/19, 2/5/19, and ts were completed on					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	IPLE CONSTRUCTION	, ,	E SURVEY IPLETED
		15K132	B. WING _		02	2/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC	•	STREET ADDRESS, CITY, STATE, ZIP C 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 572	1/29/19, 1/30/19, 1 2/4/19, 2/5/19, 2/6/ 2/10/19, 2/11/19, a 6. A review of reco care for the certific with orders for hom a day, seven days health aide visit no patient on 11/10/18 11/25/18, 11/26/18, 1 12/3/18, 12/5/18, 1 12/12/18, 12/14/18 and 12/22/18. A review of an aud evidenced the plan period of 1/3/19 - 3 or faxed to the phy agency provided the certification period document evidence visit the patient 5 h week, and the skille week for 9 weeks. A review of the hor evidenced aide visi 1/6/19, 1/7/19, 1/8/ 1/13/19, 1/22/19, 1 1/26/19, 1/27/19, 1 and 2/10/19. A review of the skill	/26/19, 1/27/19, 1/28/19, 1/31/19, 2/1/19, 2/2/19, 2/3/19, 19, 2/7/19, 2/8/19, 2/9/19, and 2/13/19.  ord # 4 evidenced a plan of ation period of 11/4/18 - 1/2/19, he health aide services 5 hours a week. A review of the home tes, the aide failed to visit the 3, 11/19/18, 11/23/18, 11/24/18, 11/28/18, 11/30/18, 12/1/18, 2/7/18, 12/8/18, 12/9/18, 12/15/18, 12/19/18, 12/21/18, it trail document dated 2/7/19 of care for the certification /3/19 was not created, saved, sician until 2/7/19. After the health aide was to ours a day, seven days a red nurse was to visit once a he health aide visit notes its on 1/3/19, 1/4/19, 1/5/19, 1/10/19, 1/11/19, 1/12/19, 1/15/19, 1/16/19, 1/20/19, 1/23/19, 1/24/19, 1/25/19, 1/28/19, 1/31/19, 2/1/19, 2/2/19, 1/28/19, 1/31/19, 2/1/19, 1/24/1	G	572		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		E SURVEY MPLETED
		15K132	B. WING		0:	2/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 572	Continued From page	e 39 on 2/14/19 at 2:20 PM, the	G 57	2		
	owner indicated there patient #4's staff and	e was a huge turnover with that despite missing visit are was always covered.				
	evidence a physician care for the certificati 11/21/18. Services w physician's signature and duration of the signature	#5 on 2/13/19 failed to a signature on the plan of ion period of 9/23/18 - were provided absent of a and absent of the frequency killed nurse visits and home this plan of care. This was owing:				
	9/23/18, 9/27/18, 9/2 10/3/18, 10/4/18, 10/	s evidenced aide visits on 8/18, 0/1/18, 10/2/18, 5/18, 10/8/19, 10/9/18, 10/18/18, 10/19/18, 10/22/18,				
	office manager indica	on 2/18/19 at 12:45 PM, the ated the physician signed present in the record.				
	plan of care for the co - 2/6/17, with orders to scheduled for 7.5 how week. The clinical re	d #7 on 2/19/19 evidenced a ertification period of 12/9/16 for home health aide visits as urs a day seven days a ecord failed to evidence visits 6, 12/28/16, 1/11/17, and				
	plan of care for the co 3/9/19, with orders for be seven days a week	t #9 on 2/15/19 evidenced a ertification period of 1/9/19 - or home health aide visits to ek for 9 weeks. This plan of e how many visits a day or ay would occur.				

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	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
G 572	the patient was to be was signed by Employand the recommore than once a day visited the patient on 1/9/19 - 1/11/19 for 1 hour a day, 5 hours 1/19/19 for 3 hours, 1/24/19 for 1 hours, 1/26/19 for 1 hours, 1/26/19 for 1 hours, 2/6/18 for 7 2/8/19 for 2.5 hours, for 3 hours, on 2/14/10 for 3 hours on 2/16/19 for 3 hours of 3 hours, on 2/14/10 for 3 hours of 3 hours, on 2/14/10 for 3 hours of 3 hours, on 2/14/10 for 3 hours of 3	ted aide care plan evidenced visited 6 hours daily. This byee H, RN.  d showed visits occurred y. Employee KK, HHA, 1/9/19 - 1/11/19 for 5 hours, hour, 1/16/19 - 1/19/19 for 1 a day from 1/15/19 - 1/18/19, 1/20/19 for 1 hours, 1/25/19 for 1 hours, 1/25/19 for 1 hours, 1/27/19 for 1 hours, 2/7/19 for 4.5 hours, 2/9/19 for 3 hours, 2/10/19 19 and 2/15/19 for 7 hours, 7s.  on 2/15/19 at 11:15 AM, the ated the recently created ent #2, #3, and #4 were not a manner. In the plan of calculate the relevant hanges in the patient's last suggest that outcomes and and/or that the plan of calculate the recently created ent #2 and interview, the calculate the relevant hanges in the patient's last suggest that outcomes and and/or that the plan of calculate the relevant hanges in the patient's fall with a for active clinical records	G 57		
	J				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		X3) DATE SURVEY COMPLETED
		15K132	B. WING _			02/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		STREET ADDRESS, CITY, STATE, ZIF 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	, CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C ( (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION DATE
G 590	Nursing Service" date service is provided by or Licensed Practical Professional Nursing with professional Star each patient / family reach patient / sendit During a office observed. AM, the office manage patient #9's family on patient had fallen recommendation of the manager indicated his / her head with a reach had not been notified. During an interview of office manager indicated the offic	ed "2.6 Service Policies ed 2018 stated, "Nursing a Registered Nurses [RNs] Nurses [LPNs] [RN] functions: In keeping adards and depending upon need, all or a selection of the etions may be performed an and other staff of changes ion / needs."  Author on 2/15/19 at 10:30 er was heard speaking to phone and indicated the ently.  In 2/15/19 at 11:10 AM, the ted patient #9 had bumped recent fall at home, patient this fall, and the physician	G 5	690		
G 592	The fall report was re A review of the record documentation about or that the physician I incident.	quested but not received.  If #9 failed to show any the patient #9's recent fall had been notified of the	<b>G</b> 5	592		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION  NG		ATE SURVEY OMPLETED
		15K132	B. WING _			02/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 592	information concern toward the measural identified by the HH care.  This ELEMENT is a Based on record reagency failed to ensimilar evised and updated to duration of skilled in visits to be made in (#1, #3, #4, #9) and accurate medication interventions, and a for 1 of 1 (#4) in a securate of 1. The agency policy area and plan of the available to the age treatment must be set the chart within 30 dagency and must in duration of visits to	e patient's updated essment, and contain ing the patient's progress able outcomes and goals A and patient in the plan of not met as evidenced by: eview and interview, the sure the plan of care was include frequency and urse and home health aide 4 of 7 active clinical records 1 of 5 closed records (#5), ns, fluid restrictions, all Ill durable medical equipment ample of 12.  Ty titled "Physician's Plan of 018 stated, "A physician reatment and it is made ncy A physician's plan of signed by the physician and in days after admission to the clude the frequency and be made."	G 5		(CT)	
	2/2/16) plan of care 1/17/19 - 3/17/19 fa and duration for skil aide visits on this pl During an interview supervisor indicated	cal record #1's (start of care for the certification period of iled to evidence frequency led nurse and home health an of care document.  on 2/7/19 at 3 PM, the clinical of the plan of care lacked the tion of visits needed.				
	3. A review of clinic	cal record #3's (start of care				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K132	B. WING		02/20/2019	
	ROVIDER OR SUPPLIER	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
G 592	1/24/19 - 3/24/19 fa and duration for skil aide visits on this pluring an interview clinical supervisor in lacked the frequence.  4. A review of clinical 11/18/15) plan of ca of 1/3/19 - 3/3/19 fa orders individualized testing needs, precapressures in right are was further evidence. A review of clinical revidenced a hospital dated 2/18/18 - 3/2/document and dischevidenced the patie added to the medical discharge summary patient had a dischard possibly adjustroscharged on lantual controlled by diet buand possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual controlled in the skill and possibly adjustroscharged on lantual contr	for the certification period of led to evidenced a frequency led nurse and home health an of care document.  on 2/8/19 at 3:55 PM, the edicated the plan of care y and duration needed.  all record #4 (start of care refor the certification period led to evidence the physician of for this patient's blood sugar autions on taking blood m, and fluid restrictions. This led by the following;  ecord #4 on 2/14/19  lization discharge document 18 from an emergency room learge report summary in thad long acting insuling ation regimen on 3/1/18. The dated 3/2/18 evidenced the large diagnosis of Type 2 th neurological and renal controlled; previously it now needing basal insuling ments as outpatient s [insulin glargine] 30 units	G 59.			
	also known as blood your diabetes. It als care provider monite determine how well working When sh care provider will he	y Blood Glucose onitoring your blood glucose [ d sugar] helps you to manage to helps you and your health or your diabetes and your treatment plan is ould you test? Your health lp you decide how often you lood glucose. this may				

NAME OF PROVIDER OR SUPPLIER  BLESSED HANDS HOME CARE AGENCY LLC  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  G 592  C Continued From page 44 depend on the type of diabetes you have, your diabetes control, or the type of medicines you are taking. Be sure to write down all of your blood glucose readings so that this information can be reviewed with your health care provider. See below for examples of testing times that your health care provider may suggest Type 2  Diabetes It can vary with each person, but generally if you are on insulin, test 4 times a day How to monitor your blood glucose meter, test strips, a pricking needle [lancet], a device that holds the lancet, a journal or log book to write down your results It is a good idea to keep a daily record or log of your blood glucose readings"		DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(	X3) DATE SURVE COMPLETED	Y
BLESSED HANDS HOME CARE AGENCY LLC  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  G 592  Continued From page 44 depend on the type of diabetes you have, your diabetes control, or the type of medicines you are taking. Be sure to write down all of your blood glucose readings so that this information can be reviewed with your health care provider. See below for examples of testing times that your health care provider may suggest Type 2  Diabetes It can vary with each person, but generally if you are on insulin, test 4 times a day How to monitor your blood glucose Supplies needed Blood glucose meter, test strips, a pricking needle [lancet], a device that holds the lancet, a journal or log book to write down your results It is a good idea to keep a daily record			15K132	B. WING _			02/20/20	19
Cach deficiency must be preceded by full regulatory or list identified by the results of the appropriate results It is a good idea to keep a daily record   PREFIX TAG   CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			AGENCY LLC	,	4626 W WESTERN AVENUE	ODE		
depend on the type of diabetes you have, your diabetes control, or the type of medicines you are taking. Be sure to write down all of your blood glucose readings so that this information can be reviewed with your health care provider. See below for examples of testing times that your health care provider may suggest Type 2 Diabetes It can vary with each person, but generally if you are on insulin, test 4 times a day How to monitor your blood glucose Supplies needed Blood glucose meter, test strips, a pricking needle [lancet], a device that holds the lancet, a journal or log book to write down your results It is a good idea to keep a daily record	PRÉFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIAT	COMP	PLETION
A review of a plan of care for the certification period of 1/3/19 - 3/3/19 evidenced the nurse was to visit 1 hour a week and the home health aide was to visit 5 hours a week, 7 days a week.  Interventions include vital sign parameter notify physician if blood glucose is greater than 140 mg/dl or less than 60 mg/dl fasting random start effective 1/4/19. Nutritional requirements evidenced a diabetic diet, diet as tolerated, and a renal diet. There was no mention of fluid restrictions. Under Endocrine interventions:  Assess/ Instruct on diabetic diet, signs and symptoms of hypo/ hyperglycemia and appropriate actions to take, on blood glucose testing every [left blank] and importance or recording and compliance, and skin and diabetic foot care. There was no evidence on this document where to take the patient's blood pressure safely.  A review of a packet of information received from patient #4's in-center hemodialysis clinic received	G 592	depend on the type diabetes control, or taking. Be sure to glucose readings s reviewed with your below for examples health care provide Diabetes It can var generally if you are How to monitor y needed Blood glucopricking needle [lar lancet, a journal or results It is a goo or log of your blood A review of a plan operiod of 1/3/19 - 3 to visit 1 hour a we was to visit 5 hours Interventions include physician if blood gmg/dl or less than effective 1/4/19. Nevidenced a diabet renal diet. There we restrictions. Under Assess/ Instruct on symptoms of hypo/appropriate actions testing every [left b recording and comfoot care. There we document where to pressure safely.	e of diabetes you have, your the type of medicines you are write down all of your blood to that this information can be health care provider. See so of testing times that your er may suggest Type 2 y with each person, but e on insulin, test 4 times a day your blood glucose Supplies ose meter, test strips, a neet], a device that holds the log book to write down your od idea to keep a daily record diglucose readings"  of care for the certification /3/19 evidenced the nurse was ek and the home health aide a week, 7 days a week. He vital sign parameter notify glucose is greater than 140 so mg/dl fasting random start utritional requirements ic diet, diet as tolerated, and a was no mention of fluid Endocrine interventions: a diabetic diet, signs and hyperglycemia and to take, on blood glucose lank] and importance or pliance, and skin and diabetic was no evidence on this take the patient's blood	G	592			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	TIPLE CONSTRUCTION NG		(X3) DATE S COMPL	
		15K132	B. WING _			02/2	0/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC		STREET ADDRESS, CITY, STATE, Z 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	IP CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED DEFICI	ACTION SHOULD BI TO THE APPROPRIA	<b>I</b>	(X5) COMPLETION DATE
G 592	Standard/ above el [active] Please conadmitting orders access arm; no blochemodialysis cathe consider the followi [gram/ kilogram] progen Potassium, no dairy per day, 1500 limit including supp sweets if diabetes orders fluid 1400 6/13/18 Current le Medication list 1/25 2/11/19 Accucheck Glucose Meter] pat 12/26/18 and entern Aviva plus test strip Patient notes 3 ti 12/26/18 entered declick lancets Test 12/26/18 entered decl	current orders: "AV Fistula cow/ brachiocephalic - Right sider the following for No BP, blood draws, or IVs in od draws or IV lines in ter dietary order [please ing diet order] 1.2 Gm/kg officially supplements, 2 added salt, limit to 1 serving in cc [cubic centimeter] fluid dements, no concentrated in Current outpatient nutrition in [milliliter] Start Date: Medical info: Home in Image: Medical info: Home in Ima	G	592			
	owner indicated sta	on 2/15/19 at 4:15 PM, the ff nurses did not carry e patients were to have their the home.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		15K132	B. WING		02/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC	1	STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
G 592	Continued From pag	e 46	G 59	2	
	owner indicated patie glucometer in the hor check blood sugars a check the patient's bit.  5. A review of recomplan of care for the creative in the frequency and duvisits and home heal care.	d #5 on 2/13/19 evidenced a ertification period of 9/23/18 of care failed to evidence tration of the skilled nurse th aide visits on this plan of			
	plan of care for the c 3/9/19 evidenced the the home health aide a week for 9 weeks. evidence how many hours a day would or				
G 602	the patient was to be was signed by Emplo Communication with CFR(s): 484.60(d)(1)  Assure communication involved in the plan of This ELEMENT is not Based on record revisealth agency failed communicated new of primary care physicial discharged from the	all physicians on with all physicians of care. ot met as evidenced by: riew and interview, the home	G 60	2	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	· ,	ATE SURVEY OMPLETED
		15K132	B. WING _			02/20/2019
	ROVIDER OR SUPPLIER	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CO 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 602		: tled "2.36 Coordination of	G 6	02		
	services in order to care and assure corpersonnel involved i responsible for coor support the objective plan of care the a Ensuring communic involved in the plan from all physicians it ensure the coordina interventions provided Integrating services provided directly or the identification of provided affect patients effectiveness and the provided by all discipled to compare the identification of provided by all discipled involved by all discipled involved the identification of provided by all discipled involved in the provided by all discipled involved involved involved in the provided by all discipled involved involved involved in the provided by all discipled involved involved involved in the provided by all discipled involved involved in the provided by all discipled involved involved in the provided by all discipled involved involved in the plan from all physicians in the pl	8 stated, "1. To Coordinate provide comprehensive home atinuity of care. 2. All in the patient's care are dinating care effectively to ses outlined in the patient's gency coordinates care by a. ation with all physicians of care. b. Integrating orders involved in the plan of care to tion of all services and sed to the patient c.  whether services are under arrangement, to ensure patient needs and factors that safety and treatment e coordination of care patient's needs, and involve coordination of care activities				
	hospitalization disch - 3/2/18 from an em- discharge report sur had long acting insuregimen on 3/1/18. dated 3/2/18 eviden discharge diagnosis with neurological an uncontrolled; previo- needing basal insuli as outpatient Disc	ecord #4 evidenced a large document dated 2/18/18 lergency room document and linary evidenced the patient lin added to the medication The discharge summary linary evidenced the patient linar				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K132	B. WING			02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC		40	TREET ADDRESS, CITY, STATE, ZIP CODE 626 W WESTERN AVENUE OUTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 602	glucose [ also known manage your diabet health care provider determine how well working When she care provider will he should check your be depend on the type diabetes control, or taking. Be sure to we glucose readings so reviewed with your below for examples health care provider Diabetes It can vary generally if you are considered Blood gluco pricking needle [lance lancet, a journal or loresults It is a good or log of your blood clinical record failed	adult Monitoring your blood as blood sugar] helps you to es. It also helps you and your monitor your diabetes and your treatment plan is buld you test? Your health lip you decide how often you lood glucose. This may of diabetes you have, your the type of medicines you are write down all of your blood that this information can be nealth care provider. See of testing times that your may suggest Type 2 with each person, but on insulin, test 4 times a day our blood glucose Supplies se meter, test strips, a tet], a device that holds the tog book to write down your didea to keep a daily record glucose readings" The to evidence that the patient's as notfied of the new	G	602			
G 606	owner indicated pati glucometer in the ho blood sugars at hom the patient's blood s failed to evidence th of the patients lack of Integrate all services CFR(s): 484.60(d)(3	S )	G	606			
	Integrate services, w	hether services are provided					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K132	B. WING		02/20/2019		
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
G 606	identification of patie could affect patient seffectiveness and the provided by all discipant and the patient seffectiveness and the provided by all discipant and the patient seffectiveness and the provided by all discipant seffectiveness and the provided by all discipant seffectiveness and the provided seffectiveness and the provid	angement, to assure the ent needs and factors that safety and treatment e coordination of care olines. Not met as evidenced by: view and interview, the ure skilled nursing and home ated care amongst each rds reviewed. (#5)  Itled "2.36 Coordination of 8 stated, "1. To Coordinate provide comprehensive home attinuity of care. 2. All in the patient's care are dinating care effectively to be outlined in the patient's gency coordinates care by a lation with all physicians of care. b. Integrating orders involved in the plan of care to tion of all services and	G 60	6			
	7/17/18 and dischar	ge 10/25/18, with a diagnosis					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED		
		15K132	B. WING			2/20/2019		
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CO 4626 W WESTERN AVENUE SOUTH BEND, IN 46619				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
G 606	caring for patient #5.  A data entry note da office manager evide statement: "HHA tex supervising RN [Empreading as requested went to [Employee Db/p [blood pressure] [Employee D] asked aide, and d/t [due to aides/ clients making instructed her to call to aide since aide was [Employee D] became that I was interfering informed her due to documented] I found that aides call the offrom the patient's phhaving an RN admin have been instructed office will reach the rewisher was not able to phone numbers."  A review of an aide was interfering with she was not able to phone numbers."  A review of an aide was interfering with she was not able to phone numbers."  A review of an aide was interfering with she was not able to phone numbers."  A review of an aide was interfering with she was not able to phone numbers."  A review of an aide was interfering with she was not able to phone numbers."  A review of an aide was interfering with she was not able to phone numbers."  A review of an aide was interfering with she was not able to phone numbers."  A review of an aide was interfering with she was not able to phone numbers."  A review of an aide was interfering with she was not able to phone numbers."	ted 8/17/18 and written by the enced the following sted office manager to notify ployee D] of blood pressure d. I took the message and b's] desk to inform her of the reading sent in by CHHA. for the phone number of the j issues of the past with gharassment claims, I the patient 's phone to speak as on duty. At this time, he visibly upset and stated with coordination of care. I previous allegations [that are it to be in the best interest fice to speak to her, or call one. Due to the agency not istrator at this time, all aides it to call the office and the nurse for further instruction. became aware of this, she did document in her notes that coordination of care and that have the aides personal	G 60	6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		15K132	B. WING _			02/20/2019	
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC	•	STREET ADDRESS, CITY, STATE, 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
G 606	patient at 2 PM. The requested CHHA periodition, pain more office manager refinition and patient with the pare part of the desired the patient #5 made it is services to this patient #6 manager indicates to walk the were afraid of the cosays / she says stepeople's backs that situation. The office complaint against [didn't agree that we office manager indicated this was in of care between the office manager stat she refused to sign Coordinate care deceds, and involve coordinate care deneeds, and involve	he note also stated, "This RN hone number to update on nitoring, need VS [vital signs]. used to give this RN Aides pt's number, RN did so, no informed it was company policy he office to report any regarding their pts. This RN de need to coordinate care as interdisciplinary team."  If on 2/13/19 at 12:05 PM, the cated Employee D, past patient representative for mard for the agency to provide itent. Employee D indicated iter the situation with Employee ager indicated there was interdisciplinary team, and talking behind it made for an uncomfortable item and this wirte up."  If on 2/13/19 at 12:05 PM, the cated Employee D indicated item and talking behind item and the patient for the large dog and many aides and talking behind item and the indicated the aides. The cated the aides were to call items and Employee D interfering with the coordination is aides and nursing staff. The red, "I wrote her up for this and this write up."		608			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		15K132	B. WING _			02/2	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE  4626 W WESTERN AVENUE  SOUTH BEND, IN 46619				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
G 608	Based on record reveled health agency failed care and services with center in 1 of 1 record receiving dialysis in a services in 1 of 1 record receiving dialysis in a services in order to possible for configuration of care and assure compersonnel involved in responsible for coord support the objective plan of care the agency possible for coord support the objective plan of care the agency provided in the plan of care involved in the plan of communication of the coordination of the identification of provided directly or unthe identification of provided by all discip delivery to meet the patient in the configuration of the patien	activities.  In the tas evidenced by:  In the patient's dialysis It reviewed (#4) of a patient It a sample of 12.  It a sample of a patient a sample of a pa	G 6	508			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K132	B. WING			02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC	1	4	TREET ADDRESS, CITY, STATE, ZIP CODE 626 W WESTERN AVENUE SOUTH BEND, IN 46619	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 608	access arm; no blo hemodialysis cather consider the follow [gram/ kilogram] pr GM Potassium, no dairy per day, 1500 limit including supp sweets if diabetes orders fluid 1400 6/13/18 Current Medication list 1/25/2/11/19 Accucheck Glucose Meter] pat 12/26/18 and enter Aviva plus test strip Patient notes 3 transition 12/26/18 entered dick lancets Tes 12/26/18 entered dim Insulin glargine  During an interview Person C, the facili dialysis clinic, indicather considerations are supported to the support of the su	No BP, blood draws, or IVs in od draws or IV lines in oter dietary order [please ing diet order] 1.2 Gm/kg otein plus daily supplements, 2 added salt, limit to 1 serving of cc [cubic centimeter] fluid lements, no concentrated Current outpatient nutrition of Im [milliliter] Start Date: Medical info: Home is/19 last RN Review date Aviva Plus Meter [Blood ient use daily start date ed date 1/21/19. Accucheck of [blood sugar diagnostic] imes a day start date ate 1/21/19 Accucheck soft to 3 times a day start date ated 1/21/19 Touji - solo star inject 20 units at bedtime	G	608			
	During an interview owner indicated pa glucometer in the h	on 2/15/19 at 5 PM, the tient #4 does not have a nome and patient does not sat home. Dialysis facility may					
	coordination of care patient's in center h patient #4 received	gency failed to evidence be between the agency and the nemodialysis clinic where dialysis treatments three o End Stage Renal Disease.					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		15K132	B. WING _		02/20/2019	
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
G 622	CFR(s): 484.60(e)(5)  Name and contact in manager.  This ELEMENT is in Based on record rehealth agency failed manager's name an provided to 7 of 7 ac #9, #10).  The findings include  1. A review of the p folder with the agencinformation on the cevidence the clinical contact information.  On 2/7/19 at 1:10 Plindicated the staff arcall the office staff we concerns were passinecessary.  2. A review of clinic patient #1 received is start of care.  3. A review of clinic.	of met as evidenced by: view and interview, the home to ensure the clinical d contact information was stive patients ( # 1 - #4, #6,	G	·		
		al record #3 evidenced the admission folder at the				
		al record #4 evidenced the admission folder at the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(XX	(X3) DATE SURVEY COMPLETED	
		15K132	B. WING_			02/2	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	:	(X5) COMPLETION DATE
G 622	patient #4 indicated hoffice manager and the office manager and the office manager and the office manager and the factorial patient #6 received the start of care.  7. A review of clinical patient #7 received the start of care.  8. A review of clinical patient #10 received start of care.  During an interview of patient #10 indicated needed. Patient #10 manager was or the of clinical manager.  Quality assessment/pCFR(s): 484.65  Condition of participal and performance important manager important manager.  The HHA must developed maintain an effective data-driven QAPI probody must ensure the	n 2/11/19 at 2:30 PM, nis / her contact was the ne owner.  I record #6 evidenced ne admission folder at the  I record #7 evidenced ne admission folder at the  I record #10 evidenced the admission folder at the  I record #10 evidenced the admission folder at the  n 2/15/19 at 1:40 PM, would call office staff if did not know who clinical contact information for the  performance improvement  tion: Quality assessment provement (QAPI).  pp, implement, evaluate, and a ongoing, HHA-wide, gram. The HHA's governing at the program reflects the nization and services;		622			
	services provided und arrangement); focuse improved outcomes,	es on indicators related to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K132	B. WING			02/	20/2019	
	ROVIDER OR SUPPLIER	E AGENCY LLC	<b>'</b>	STREET ADDRESS, CITY, STATE, ZIP CO 4626 W WESTERN AVENUE SOUTH BEND, IN 46619		1 02		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
G 640	re-admissions; and HHA's performance including the prevention of the program for the provision of the program for the provision of the prevention of the provision of the prevention of the provision of the prevention of th	vices, hospital admissions and d takes actions that address the e across the spectrum of care, ention and reduction of medical nust maintain documentary PI program and be able to	G	640				
	participation: 484: Assessment / Perf	65 Condition: Quality formance Improvement.						
	Program [QAPI] da evaluate all areas plans to resolve th 1. The developme improvement plan vision, and strateg	ded:  icy "Performance Improvement ated 12/6/17 stated, "To of concern and implement e issues Special Instructions nt of a performance will be guided by the mission, ic goals of the organization.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  (X2) MULTIPLE CONSTRUCTION  (X3) MULTIPLE CONSTRUCTION  (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION  (X6) MULTIPLE CONSTRUCTION  (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION  (X8) MULTIPLE CONSTRUCTION  (X9) MULTIPLE CONSTRUCTION  (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  (X2) MULTIPLE CONSTRUCTION  (X3) MULTIPLE CONSTRUCTION  (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION  (X6) MULTIPLE CONSTRUCTION  (X7) MULTIPLE CONSTRUCTION  (X7) MULTIPLE CONSTRUCTION  (X8) MULTIPLE CONSTRUCTION  (X9) MULTIPLE CONSTRUCTION  (X9) MULTIPLE CONSTRUCTION  (X9) MULTIPLE CONSTRUCTION  (X1) MULTIPLE CONSTRUCTION  (X2) MULTIPLE CONSTRUCTION  (X2) MULTIPLE CONSTRUCTION  (X3) MULTIPLE CONSTRUCTION  (X4) MULTIPLE CONSTRUCTION  (X5) MULTIPLE CONSTRUCTION  (X6) MULTIPLE CONSTRUCTION  (X7) MULTIPLE CONSTRUCT			(X3) DATE SURVEY COMPLETED				
		15K132	B. WING _			02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		4626 W V	ADDRESS, CITY, STATE, ZIP CODE WESTERN AVENUE BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
G 640	will be prioritized by to team data will be of to monitor its perform collected, measured,  A review of the agend Position" Quality Imp 2018 stated, "Title of Director of Nurses development, implemente Continuous Quality and activities that surin delivering quality position delivering quality position." dated 2 Duties shall be to organizational and positivities."  A review of the agend on 2/7/19 failed to ship program was in effect data, and other evide ongoing, effective quality assurance were lacking at this time. At the entrance confearm, the quality assurance were lacking at 4:20 Program was requested. At 4:20 Program was requested the surror collection of the surror confearm, and other evidence of the quality assurance were lacking at this time.	the agency's management collected to allow the agency france. Data will be and analyzed"  By document titled "Title of rovement Manager" dated Immediate Supervisor: Duties: Assist in the frentation, and evaluation of ty Improvement Program oport the Agency's objectives atient care services "  By policy titled "1.19 Agency 0.18 stated, "Administrator's direct and monitor erformance improvement  By documents and interviews ow a quality assurance and had plans, measurable frace of a functioning, ality assurance program.  The office manager indicated a meetings and program me.  By the quality assurance are dealy again and the office the documents. The office occuments provided was the sentirety.	G	340			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		ISTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K132	B. WING				02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	AGENCY LLC		4626 \	ET ADDRESS, CITY, STATE, ZIP CODE N WESTERN AVENUE I'H BEND, IN 46619			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
G 640	Care Agency LLC fo stated, "On 12/4/18 Directors of Blessed Professional Advisor following directors w [the owner, Presider President; Employee Employee B, clinical Employee T, Data elevaluation In review success, the office obrought up many pocensus of 16 patient and of those 11 4 an interest that the comclients at this time r/b be presented in this % of the current recepaperwork is missing some are incomplete [Employee B] the clinjob, thus making it in at the max capacity noted that there hav surveys quarterly to The RN's in the field complaints from the the office. There has agency budget and routline key agency of finance [the owner] Indistribute a budget for the company function place, and patient calespecially with the noral sed by clients. Stopped the company function place, and patient calespecially with the noral sed by clients. Stopped the company function place, and patient calespecially with the noral sed by clients. Stopped the company function place, and patient calespecially with the noral sed by clients. Stopped the company function place, and patient calespecially with the noral sed by clients. Stopped the company function place, and patient calespecially with the noral sed by clients. Stopped the company function place, and patient calespecially with the noral sed by clients. Stopped the company function place, and patient calespecially with the noral sed by clients.	of Blessed Hands Home r Profit Home Health Agency" at 10:30 AM, the Board of Hands called for a y Committee Meeting. the ere present at the meeting: at; Employee V, Vice e A, office coordinator; manager; Employee H, RN; atry clerk]. Agency ng the agency's overall oordinator [employee A] had ants. First, the agency has a s with 11 being HHA patients e skilled. It is in the best pany not take on any more the disorganization that will meeting. After review of 10 ords, it is noted that g, recerts are done late and e but have been processed. acid manager works another appossible for her to function of her role. It has also been the been no client satisfaction measure patient satisfaction. are bringing back concerns/ clients, whom are not calling we been no review of the no meetings for leadership to objectives. The director of	G	640				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEPLAY OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15K132	B. WING _			02/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		STREET ADDRESS, CITY, STAT 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
G 640	clients that are currer reviews of active cha quarterly. There is a implemented for all of the clinical team has appointments: The aqualified candidate to alternate administrate manager role. The appoint a medical direction of an undate evidenced the following addressed and development are and submitting the Odiscovery, we have for the agency has writting going forward for OA least 1 X monthly. The that every 60 days for brought to the attention advisory staff that, that is necessary for the serview outcome based Quarterly review: 10 closed, all disciplines categories and rehos indicators of quality are presenting the scopreviews, General find was appropriate, ade meeting client needs, improvement are addimembers, and with in carried out via text medicators of the serview out via text members, and with in carried out via text medicators of quality are presenting client needs, improvement are addimembers, and with in carried out via text medicators.	nt. It is also noted clinical rts are not being done plan of correction being f this issues that myself and found. Agency gency does not have a apply for the administrator / or or alternate clinical gency has yet to find and ector."  ed document with no title ng: "The team has oped clinical expectations in and OASIS submissions. It ag of the agency that the cord system was exporting ASIS data. Upon recent ound that it isn't the case. en a plan of correction and SIS sets will be submitted at the sets should occur no less on of the professional paining in regard to OASIS Cotaff nurses. Clinical record ed quality management: records selected, open and variety of diagnostic pitalizations, focus on and utilization, Clinical staff of the of services provided in the ings demonstrated that care quate, and effective in	Ge	540		

	DF DEFICIENCIES CORRECTION				(X3) DATE SURVEY COMPLETED	
		15K132	B. WING _			02/20/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	•	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 640	low frequency, newhich potentially decline in health so This year we continued work in the areas ensuring each progrelated to their dia In-depth documer educated the profession of the professi	at list potential adverse events, agative and untoward events reflect a serious health issue or status for an individual client. Sinue to process improvement of in-depth documentation, ofessional is educations clients agnosis, and client falls. Intation: the agency has ressional staff entering client cure they are documenting to diagnosis, and absenteeism, and absenteeism, and continuity of nursing visits, comply, less breaches of HIPAA, and continuity of nursing visits, comply, less breaches of HIPAA, and continuity of nursing visits, comply meetings, in-service and documentation time, are documentation		580		
	CFR(s): 484.70  Condition of Parti and control.  The HHA must mainfection control puthe prevention and communicable distribution to the communicable distribution control passed on record	cipation: Infection prevention aintain and document an program which has as its goal d control of infections and				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	· /	TE SURVEY MPLETED
		15K132	B. WING _		,	2/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC	1	STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 680	failed to maintain a coprogram for the survey prevention, control, and communicable of the information into the assurance and performation for 1 of 1 ago.  The cumulative effect resulted in the home ensure the provision safe environment for participation: 484.70 Infection prevention afforms include:	of 1 agency (see G 680); coordinated agency-wide cillance, identification, and investigation of infections iseases and incorporated agencies QAPI (quality armance improvement) and of these systemic problems agency's inability to agency in a the condition of agency in a c	G 6	80		
G 706	supervisor, indicated infection control prog about where the infection agency. There has agency. There has agency. There has agency. There has a control agency and a review of the infect evidenced the entries February and March documentation in the Interdisciplinary assecting CFR(s): 484.75(b)(1)  Ongoing interdisciplination patient; This ELEMENT is not about where the infection of the infectio	no involvement with the ram and no knowledge ction control program was at ad been no infections since with the agency in August documentation of a program rch 2018.  ion control log on 2/19/19 is for infection activities for 2018. There was no other log for later in 2018.	G 7	06		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K132	B. WING _			02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP C 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
G 706	skilled nurse went of had fallen and bump conversation overher fallen. (#9)  Findings include:  The agency policy ti Nursing Service" day service is provided by or Licensed Practical Professional Nursing with professional State each patient / family following nursing fur informing the physic in the patient's cond.  During a office obse AM, the office manapatient #9's family of had a fall recently.  During an interview office manager indice that had no concern the office manager indice that had no concern to visit patient #9 sin been reported by the The fall report was made and the record of the re	y failed to ensure that a put to assess a patient who hed their head for 1 of 1 ard of a patient who had teld "2.6 Service Policies ted 2018 stated, "Nursing by Registered Nurses [RNs] Il Nurses [LPNs] g [RN] functions: In keeping andards and depending upon need, all or a selection of the actions may be performed itian and other staff of changes ition / needs."  Tryation on 2/15/19 at 10:30 ger was heard speaking to a phone and indicated patient to 2/15/19 at 11:10 AM, the ated patient #9 had bumped recent fall at home and the	G 7	706			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		15K132	B. WING			02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC	•	46	TREET ADDRESS, CITY, STATE, ZIP CODE 626 W WESTERN AVENUE OUTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 706	patient representative The patient's representative The patient's representative The patient's representation and bumper the head disappeared was fine. The patienthe Emergency Medithe house, and transwas declined.  During an interview of Employee H indicate the agency not to vis Home health aide se CFR(s): 484.80	on 2/19/19 at 11:55 AM, the e for patient #9 was called. Intative indicated the patient ed his / her head, a bruise on d quickly, and the patient t's representative indicated cal Personnel had come to port to the emergency room on 2/20/19 at 3:35 PM, d being told by the owner of it patient #9 after the fall.		706			
	services. All home health aide by individuals who m requirements specific section. This CONDITION is Based on home visit and interview, the ag home health aides or evaluation program a in good standing on tor home health aide reviewed of staff who aides for the agency home health aide vis on the home health a active patients who whealth aide observation ensure a home health allowed under state I	services must be provided eet the personnel ed in paragraph (a) of this not met as evidenced by: observation, record review ency failed to ensure all ompleted a competency and / or were currently listed he state nurse aide registry registry for 4 of 15 records to worked as home health (see G 752), failed to ensure aide plan of care for 1 of 3 vere observed at a home on (see G 798) and failed to a aides only completed tasks aw during home visits for 2 erved with a home health					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER  HANDS HOME CARE A	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETION
G 750	Continued From pag	ge 64	G 7	50	
		e clinical records reviewed de services (see G 800).			
G 754	resulted in the home ensure the provision safe environment for Participation 484.80	Home Health Aide Services. successfully completed:	G 7	54	
	successfully comple (i) A training and cor as specified in parago of this section; or (ii) A competency ev the requirements of or (iii) A nurse aide trait evaluation program a meeting the requirer §483.154 of this cha good standing on the (iv) The requirement program that meets (b) and (c) of this se This ELEMENT is n Based on record rev agency failed to ens completed a compet and/ or were current the state nurse aide registry for 4 of 15 re	raphetency evaluation program graphs (b) and (c) respectively raluation program that meets paragraph (c) of this section; raining and competency approved by the state as ments of §483.151 through pter, and is currently listed in e state nurse aide registry; or is of a state licensure the provisions of paragraphs ction.  ot met as evidenced by: view and interview, the ure all home health aides tency evaluation program ly listed in good standing on registry or home health aide ecords reviewed (#J, L, N, S) as home health aides for the			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K132	B. WING		02/20/2019	
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619			
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G 754	Aide Service" dated Home Health Aide demonstrated or old before they are perdoes not have door in performing the tacare."  2. A review of the Hiring" dated 2108 Nonlicensed Persoare qualified for the all individuals min accordance with regulations and ag  3. A review of the Qualifications" dated Aides 1. Must have program of at least	policy titled "2.52 Home Health d 2018 stated, "Duties of a The nurse or therapist is oserve the skills involved formed by an HHA if the HHA umented training or experience asks prescribed in the plan of policy titled "Screening and stated, "Licensed and nnel will they demonstrate they e position they are applying for ust meet the minimum qualified applicable laws and ency job description."  policy titled "Employee ed 2018 stated, "Home Health e completed an aide training 75 hours which conforms to	G 754			
	hire date and first pevidence the home standing on the standing of sta	ployee J's file, with unknown patient contact date, failed to the health aide was listed in good attenurse aide registry or home of the health aide was listed in good attenurse aide registry or home of the health aide may be a 11/3/16 for this employee.  If on 2/14/19 at 2:20 PM, the apply the maide when she will be alth aide when she alth aide when she alth aide with a hire date patient contact date of a this home health aide did not				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION		E SURVEY PLETED
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	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC	STREET ADDRESS, CITY, STATE, ZIP CO 4626 W WESTERN AVENUE SOUTH BEND, IN 46619		•	
(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 X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 754	Continued From page	e 66	G 7	754		
	3/7/17. The file evide checklist dated 5/17/homemaker compete The home health aids 5/12/16 with a score	ency checklist dated 5/18/16. e competency test was dated of 87%.				
	unknown hire date ar failed to evidence the in good standing on t or home health regist included a home hea	byee N's file, HHA, with and first patient contact date home health aide was listed the state nurse aide registry try. The personnel file lth aide/ job description yee on 2/3/17. There was no t in the record.				
	office manager indica	on 2/19/19 at 1:30 PM, the ated the employee worked as adant and not a home health				
	date of 12/28/16 and	oyee S's file, HHA, with a hire first patient contact 3/5/17 s employee had been placed				
	owner of the agency was not on the aide r aide or CNA.	on 2/18/19 at 4:15 PM, the indicated this staff member egistry as a home health				
G 798	Home health aide as CFR(s): 484.80(g)(1)	_	G 7	798		
	duties.  Home health aides a patient by a registere	alth aide assignments and re assigned to a specific d nurse or other appropriate with written patient care				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		ATE SURVEY DMPLETED
		15K132	B. WING			02/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CO 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
G 798	instructions for a hot that registered nurs professional (that is speech-language p therapist). This STANDARD is Based on observatinterview, the agenchealth aide visits with aide care plan was maded of 3 active patient home health aide of The findings included The agency policy to Service dated 2018 Health Aide Service provides services the physician ii. includes specific service standard contained a playeriod of 12/25/18 home health aide (If or 9 weeks. Intervalide's care were not signed by Employed were be completed as assisted bath or assist with dressing pressure areas, nai	me health aide prepared by se or other appropriate skilled s, physical therapist, athologist, or occupational s not met as evidenced by: tion, record review, and cy failed to ensure home ere furnished as ordered on and failed to ensure the aide e available to the employee for ts who were observed at a bservation (#10).  ed: titled "2.52 Home Health Aide 8 stated, "Definition of Home e a. A home health aide nat are: i. ordered by the ed in the plan of care ndards: a. Assignment of	G 79	8		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		15K132	B. WING _		02	/20/2019	
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
G 798	1:40 PM, Employee F clean the patient's ho any personal care tas Employee P was asket tasks as listed on the P indicated she did no available.  During an interview of patient #10 indicated independently and did care, and his/her nail During an interview of clinical manager indicated tweaking.  Services provided by CFR(s): 484.80(g)(2)	bservation on 2/15/19 at P, HHA was observed to only ome and failed to complete sks. During this time, ed why she did complete the aide care plan. Employee of have an aide care plan of his/her personal care.  In 2/15/19 at 1:40 PM, his/she would take a shower did all of his/her personal care.  In 2/18/19 at 11 AM, the cated the aide care plan of his/her plan of hi		798			
	and (iv) Consistent with the This ELEMENT is not Based on observation interview, the home hensure a home health allowed under state late of 3 home visits observation in the state of 3 home health aide (Enterview).	ne home health aide training. The home as evidenced by: The name as evidenced by: The home health agency failed to The home health agency failed to The home health agency failed training. The home health aide training. The hom					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		15K132	B. WING _		02/20/2019
NAME OF PROVIDER OR S BLESSED HANDS HO		GENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CO 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	
PREFIX (EAC	H DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
Medication be administ with their stregulations procedure.  2. The agent Health Aid health aided by the phypermitted to consistent.  3. The agent Tasks to Ustated, "The all nursing in accordate degree of determined appropriate delegated dressings.  4. A review 2/14/19 and dated 1/3/reinforce of During a health aided 1/3/reinforce of the consistent.	gs include: ency policy "dated 20 stered by F skill, training, and esta s. ency docur e Service" e provides sician ii. in to be perfor with the hore ency policy nlicensed he RN shall tasks dele nce with th supervision d by the RI e factors non - st f. admin w of clinica d 2/20/19 19 with a p lressing.  ome visit of a bed bath ressing off		G 8		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		15K132	B. WING _			02	/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619			
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G 800	Continued From page	ge 70	G 8	300			
	then applying a dres	a notch into the gauze and ssing onto the site with a 4 X 4 this dressing into place.					
	_	on 2/20/19 at 2:25 PM, the byledge that the dressing ed.					
	evidenced the aide	ide care plan dated 1/3/19 was to apply numbing cream dnesday, and Friday to dialysis					
	1/3/19 and signed by "Patient receives (a every day. MWF [Maides assist pt [patien dialysis by giving m	t case conference note dated by Employee H, RN, stated, ide services) 5 hours a day flonday, Wednesday, Friday] ent] in getting ready for ed cues, fixing breakfast, of client, applying numbing ee."					
	1/7/19, 1/11/19, 1/1 1/18/19, 1/21/19, 1/	it records dated 1/4/19, 1/9/19, 2/19, 1/14/19, 1/16/19, 23/19, 1/25/19, 1/30/19, 19, 2/10/19, 2/13/19 evidenced had been applied.					
	patient #4 indicated applied approximate for dialysis treatmer	on 2/11/19 at 2:30 PM, needing the numbing cream ely a half hour before leaving at and the home health aide task when necessary.					
		on on 2/11/19 at 3:15 PM, it umbing cream was Lidocaine e 2.5 % ointment.					
	During an interview	on 2/11/19 at 3:15 PM,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		15K132	B. WING			02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		46	REET ADDRESS, CITY, STATE, ZIP CODE 626 W WESTERN AVENUE OUTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 800	assistance with the acream due to visual papply the cream. The the cream applied an before the patient attereatments three time.  During a phone interverson D, a nurse at indicated the patient ocream.  Organization and addr. CFR(s): 484.105	dicated the patient needed dministration of the numbing problems and the inability to be patient's arm was washed, d then plastic wrap applied ended hemodialysis		940			
	administration of serve The HHA must organ its resources to attain practicable functional optimal care to achievidentified in the patient patient's medical, nurneeds. The HHA must and supervisory function another agency or organizational structure authority, and services This CONDITION is Based on observation interview, the Govern the agency was providently goals and outcome careplans, assure the supervisory functions	rices. rize, manage, and administer a and maintain the highest capacity, including providing we the goals and outcomes nt's plan of care, for each sing, and rehabilitative st assure that administrative tions are not delegated to ganization, and all services are monitored and must set forth, in writing, its are, including lines of st furnished. not met as evidenced by: n, record review and ning Body failed to ensure ding optimal care to achieve nes identified in the patients					

OLIVILIV	O I OIT MEDIO/IITE &	MEDIO/ ND OLI WIOLO				CIVID ITC	. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		15K132	B. WING			02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		4	TREET ADDRESS, CITY, STATE, ZIP CODE 626 W WESTERN AVENUE COUTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 940	Manager to assume to Clinical Manager was ensure orgazinational 1 of 1 agency (see G Governing Body assure or the agency's over operations, fiscal operations, fiscal operations, fiscal operations, fiscal operations, fiscal operations, fiscal operations or alternate could be Governing body failed Administrator appoint day to day operations failed to ensure a clinical during all operating the ensure all home heal competency evaluation currently listed in good nurse aide registry or (see G 952); failed to administrator was dewrity to asseme the sobligations as the addiction of Clinical Manager failed patient care services failed to ensure the conditional deferrals.  The cumulative effective resulted in the home ensure the provision safe environment for	cy had an alternate Clinical the responsibilities when the continuous and failed to a structure were accurate for 940); failed to ensure the sumed full legal responsibility all management and the trations, review of the cy assessment and an until an administrator and/put into place (G 942); and to ensure they had an ted to be responsible for all to of the agency (G 948); and manager was available ours (see G 950); failed to the aides completed a con program and / or were and standing on the state of home health aide registry ensure that an alternate signated and authorized in the amount of the continuous (see G 964); the continuous continuous (see G 964).  It of these systemic problems health agency's inability to of quality health care in a the condition of S Condition: Organization is Services.	G	940			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		15K132	B. WING _			02/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP 0 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 940	Continued From particles of the agency policy of the agency working hours. 2. administrator is audirector the agency administrator shall responsibility of the agency. b. Design Governing Body at to assume the samobligations as the may be the clinical available, or has a during all operating clinical manager is hours. e. Organize operations to assume the comperations to assume the comperations to assume the samobligations and grading all operating clinical manager is hours. e. Organize operations to assume the comperations to assume the samo for the agency and and error applicable laws an liaison among the committee, staff ar that the agency en including assuring qualifications and	age 73  icy titled "1.19 Agency I 2018 stated, "The Governing ed the appointment of a clinical y also be the administrator. be available at all times during Administrator's duties: The thorized to organize and y's ongoing functions. The	GS	DEFICIEN		
	information materia budget and account operations in account parameters r. Substitution periodic reports of financial statement	the accuracy of public als implement an effective nting system and manage rdance with established fiscal mit to the governing body agency activity including as oversee the agency's				

	DF DEFICIENCIES CORRECTION					
		15K132	B. WING	·····		2/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC	,	STREET ADDRESS, CITY, STATE, ZIP CO 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 940	needed depending of provided by the agen 2. During observation was observed that not administrator was averthe agency. The agricultural The agency of the analysis of the agency of the ag	athorize the hiring of al, and clerical positions as a the volume of services cy."  In from 2/7/19 - 2/20/19, it is administrator or alternate allable to organize and direct ency operated Wednesday -  H / Acute Care Program 8 evidenced the Employee and resigned from the a effective 4/11/18 and a e administrator / clinical and 2/1/18. The agency had at documentation about the open positions in this letter ency had planned to have  M, Employee A, office there was no administrator or or currently at the agency. If the clinical supervisor, all time job elsewhere and y during this time but could was no alternate clinical	G 94	40		

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
		15K132	B. WING _			02/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC	,	STREET ADDRESS, CITY, 4626 W WESTERN AVEN SOUTH BEND, IN 460	NUE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORI	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 940	indicated April - Mano administrative structures (Employee I, A document titled "Eagency" presented Employee A, office writer's request to sclinical services possince the agency st March 2017 evidendirector of nursing walternate administration nursing were Employee B, I the alternate administrator and a were Employee B, I the alternate administrator and Employee E, C 2017 showed the administrator and Employee E, C 2017 showed the administrator vacant alternate administrator vacant 2018, there was no clinical supervisor in evidenced the clinic RN. There was no A letter written by the 7/1/18 evidenced the open management zip recruiter, and in the agency lacked a supervisor and the agency lacked as supervisor and	M, the office manager y 2018 was a tense time with aff in place. There was a RN) working at the agency.  Blessed Hands Home Care 2/8/19 and prepared by manager, was written at how all of the administrator / sitions and dates of inception art on November 13, 2014. Ced the administrator and was Employee D, RN, and the ator and alternate director of one by eB, RN. March 2017 inistrator and director of one by eB, RN, and the alternate director of one by eB, RN, and the alternate director of nursing RN. August 2017 evidenced distrator was Employee F, RN linical Manager. November diministrator was Employee A, and director of nursing and alternate the administrator / alternate to the administrator / alternate to the administrator of alternate and manager was Employee B, alternate director of nursing.  The owner of the agency dated are agency was recruiting for positions including facebook, deed. This letter evidenced an administrator, alternate all manager, and alternate	G	940		

AND DUAN OF CORRECTION IN IMPER.		` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K132	B. WING			02/20/2019
	ROVIDER OR SUPPLIER	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CO 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 940	writer presented the office manager's dis from the ISDH which agency. The owne of this letter and was existence.  3. A review of a res who applied for the agency. This resum This resume was not manager did not have Administration. The degree in health car completed in Januar During an interview office manager indicated he During an interview owner indicated the finished her degree accurate.  4. A review of the overidenced auxiliary organizational chart included physical the therapist, speech the worker.	on 2/19/19 at 11:35 AM, the owner with a copy of the continuation as administrator in had been sent to the r did not indicate knowledge is surprised about this letter's ume for the office manager administrator position for the ne was presented on 2/19/19. It accurate since the office we a Bachelor's in Health Care is resume evidenced the e administration had been	G 94			
	indicated the agency and home health aid	y only offered skilled nursing				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	RIPLE CONSTRUCTION  NG	1, ,	DATE SURVEY COMPLETED
		15K132	B. WING _			02/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC	•	STREET ADDRESS, CITY, STATE, ZIP CO 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 940	Continued From pa	ge 77	G	940		
G 942	_		G 9	942		
	functioning) must as responsibility for the management and o home health service the agency's budge and its quality assesimprovement progra. This STANDARD is Based on record reagency failed to ensexercised full legal overall management operations, review of	or designated persons so ssume full legal authority and e agency's overall peration, the provision of all es, fiscal operations, review of t and its operational plans, ssment and performance				
	Guidelines" dated 2 shall be the policy or render home health the highest medical board of directors, a body, assumes full and accountability fincluding the agency affairs. The Govern the agency's bylaws	itled "Agency Organizational 018 stated, "Introduction: It of the agency to strive to care services according to and ethical standards. The also known as the governing legal authority, responsibility, or the operation of the agency, y's management and fiscal ning Body adopts and reviews and articles of incorporation available 7 days per week 24				

STATEMENT OF D AND PLAN OF CO	DEFICIENCIES PRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	IPLE CONSTRUCTION		(X3) DATE S COMPL	
		15K132	B. WING _			02/2	20/2019
	IDER OR SUPPLIER	GENCY LLC	1	STREET ADDRESS, CITY, STATE, ZIP 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	CODE		
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ho A fa quin by agure marar The Acient Cist. Die Properties of the Ender of the End	illed to evidence the palified administrator place, a budget way relaws had occurred gency for its organizoheld, the clinical manager was availabilited a quality assurant active.  The agency document discovery Committee of are Agency LLC for ated, "On 12/4/18 a irectors of Blessed For fessional Advisory Illowing directors were owner, President resident; Employee T, Data en relawable of those T, Data en relawable of those 11 4 are terest that the compients at this time r/t expresented in this not of the current record aperwork is missing one are incomplete imployee B] the clinib, thus making it im	ey from 2/7/19 - 2/20/19 governing body had a r or alternate administrator is in place, review of agency , accountability of the ational structure was anager or alternate clinical le during all operating hours, ce program was functioning  at titled "Professional of Blessed Hands Home Profit Home Health Agency" to 10:30 AM, the Board of Hands called for a r Committee Meeting. the are present at the meeting: ; Employee V, Vice A, office coordinator; manager; Employee H, RN; try clerk]. Agency ag the agency's overall ordinator [employee A] had ats. First, the agency has a with 11 being HHA patients skilled. It is in the best any not take on any more the disorganization that will meeting. After a review of 10	G	042			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		NSTRUCTION	` ′	E SURVEY PLETED
		15K132	B. WING			02	/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC	•	4626	ET ADDRESS, CITY, STATE, ZIP CODE W WESTERN AVENUE TH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
G 942	The RN's in the fiel complaints from the the office. There hagency budget and outline key agency finance [the owner distribute a budget the company functiplace, and patient especially with the raised by clients. So that have been her raises. Raises are clients that are curreviews of active of quarterly. There is implemented for all and the clinical tea appointments: The qualified candidate alternate administry manager role. The appoint a medical of the Area of OASIS and reason that the lact data had occurred. Will be done month explain what would agency including in improvement process tracking and absent education related to randomly, less breasustain continuity of the sustain continu	o measure patient satisfaction. Id are bringing back concerns/ e clients, whom are not calling ave been no review of the I no meetings for leadership to objectives. The director of I has not found time to for the company. At this time, cons without an administrator in care is becoming a concern, number of complaints being Staff retention is at a low staff the believe they should receive n't feasible with the number of rent. It is also noted clinical marts are not being done a plan of correction being I of these issues that myself m has found. Agency the agency does not have a to apply for the administrator / ator or alternate clinical the agency has yet to find and	G	942			

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  BLESSED HANDS HOME CARE AGENCY LLC  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  G 942  Continued From page 80 transcribed by Employee T, the data entry clerk. There was no date. There was no date administrator, Employee A, had resigned 4/11/18 and the alternate administrator / clinical supervisor (past Employee B) had resigned 4/11/18, a lack of alternate administrator since 4/11/18, a lack of alternate clinical supervisor since November 2017.  A document titled "Blessed Hands Home Care Agency administration timeline" prepared by Employee A, office manager on 2/8/19 evidenced  STREET ADDRESS, CITY, STATE, ZIP CODE 4625 WESTERN AVENUE  SOUTH BEND, IN 46619  PREFIX CACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPRIATE DAT			15K132	B. WING			02/	20/2019
PREFIX TAG  (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO HE APPROPRIATE DEFICIENCY)  (G 942  (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO HE APPROPRIATE DEFICIENCY)  (FACH CORS-REFERENCED TO HE APPROPRIATE DEFICIENCY)  (G 942  (FACH CORS-REFERENCED TO HE APPROPRIATE DEFICIENCY)  (FACH CORS-REFERENCED TO HE APPROPRIATE DEFICIENCY)  (G 942  (FACH CORS-REFERENCED TO HE APPROPRIATE DEFICIENCY)  (FACH CORS-REFERENCED THE APPROPRIATE DEFICIENCY)  (FACH CORS-RE			GENCY LLC	•	4	626 W WESTERN AVENUE		
transcribed by Employee T, the data entry clerk. There was no date. There was no data or active programs in place.  A review of the department's documents on 2/7/19 evidenced the administrator, Employee A, had resigned 4/11/18 and the alternate administrator / clinical supervisor (past Employee B) had resigned effective 2/1/18. A review of other documents evidenced a lack of administrator since 4/11/18, lack of alternate administrator since 2/1/18, a lack of alternate clinical supervisor since November 2017.  A document titled "Blessed Hands Home Care Agency administration timeline" prepared by Employee A, office manager on 2/8/19 evidenced	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
November 13, 2014: Employee OO, RN, administrator, and director of nursing Employee PP, alternate administrator and alternate director of nursing.  March 5, 2015: Employee E, administrator, and director of nursing Employee PP, alternate administrator and alternate director of nursing  March 2016: Employee PP, administrator, director of nursing Employee PP, alternate administrator  March 2017: Employee PP, alternate administrator  No alternate director of nursing  March 2017: Employee D, administrator, and director of nursing  Employee B, alternate administrator and alternate director of nursing	G 942	transcribed by Emplo There was no date. I programs in place.  A review of the depar 2/7/19 evidenced the had resigned 4/11/18 administrator / clinica B) had resigned effect other documents evid administrator since 4/ administrator since 2/ clinical supervisor sin  A document titled "Ble Agency administration Employee A, office m the following:  November 13, 2014: administrator, and dir administrator and alte March 5, 2015: Empl director of nursing Employ administrator and alte March 2016: Employ director of nursing Employ administrator No alte  March 2017: Employ director of nursing Employ administrator Ro alte	tment's documents on administrator, Employee A, and the alternate I supervisor (past Employee etive 2/1/18. A review of lenced a lack of /11/18, lack of alternate ce November 2017.  Lessed Hands Home Care in timeline" prepared by anager on 2/8/19 evidenced  Employee OO, RN, ector of nursing  Employee PP, alternate ernate director of nursing.  Loyee E, administrator, and loyee PP, alternate ernate director of nursing yee PP, alternate yee PP	G	942			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		15K132	B. WING		02/20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	,
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G 942	Continued From pa	age 81	G 94	12	
	administrator Emp nursing Emp (con administrator)  November 2017: E administrator, and April 2018: Admini administrator: Ope August 2018: Emp The agency docum presented 2/19/19 the following positic Payroll Clerk / Hum Nurse. The dates was dated June 29 A review of a resur applied for the adm agency. This resur This resume was n manager did not ha Administration. Th degree in health ca completed in Janua During an interview office manager indi	strator / alternate en  bloyee B, RN clinical manager.  ment titled "Indeed" and evidenced advertisements for ons: HHA, RN administrator, man Resources, Registered on these May 3rd, 2018. LPN 1, 2018.  me for the office manager who ministrator position for the me was presented on 2/19/19. ot accurate since the office ave a Bachelor's in Health Care we resume evidenced the me administration had been			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  NG	1' '	(X3) DATE SURVEY COMPLETED	
		15K132	B. WING		02	2/20/2019	
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619			
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G 942	owner indicated the a qualified staff for the a administrator, and alt The budget was not in reviewed and that the was lacking.  During an interview o office manager indicated has During an interview o owner indicated the owner indicated the original staff.	ently.  n 2/7/19 at 1:55 PM, the gency had yet to find administrator, alternate ernate clinical supervisor. In place and had not been equality assurance program  n 2/20/19 at 11:10 AM, the ted not finishing her degree	G	942			
G 950	paragraph (c) of this soperating hours; This ELEMENT is not Based on observatio interview, the agency manager was available for 1 of 1 agency.  The findings include: The agency policy titl Supervision" dated 20 Body was approved to manager, who may a This person shall be a	cal manager as described in section is available during all t met as evidenced by: n, record review and failed to ensure a clinical le during all operating hours	G	950			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUC		(X3) DATE	SURVEY PLETED
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G 950	administrator is auth the agency's ongoing administrator shall be responsibility of the agency. b. Designat Governing Body and to assume the same obligations as the admay be the clinical savailable, or has a quering all operating the clinical manager is a hours."  On 2/7/19 at 10:48 A manager indicated the Employee B, had a fat this time but coulcalternate clinical suptime. There was no agency at this time.  A review of personneevidenced an accept part-time of RN. The this employee would the letter stated, "Down Welcome to Blessed I am pleased to confoffer for the part-time to [Employee D, a pasalary will be at the redelighted you are join Home Health Aide [r is critical in fulfilling During your first few co-workers, supervisites ource staff. We assume the summary of the part in the	orized to organize and direct g functions. The e to: a. Assume day to day operations of the e, in conjunction with the in writing, a qualified person	G	950			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  HANDS HOME CARE	AGENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	CODE		
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G 950	to accomplish your contact [office mana offs and [office mana nay need Sinceredief operations mathe clinical supervised document was 25 heromagnetic office to the weather.  Per office telephone Employee A indicate clinical supervisor to not returned until 1::  During a face time power power of the weather and the could not get out to the weather and the could not get out to the weather and the office. This we manager at this time.  During an interview clinical supervisor we in the office. This in the office manager at the office manager and the	let them know what you need new responsibilities. You may iger] for scheduling and call ager] for employment y human resource things you ely, [office manager signature, nager]. This was signed by or also. Handwritten on this ours/ week.  AM, Employee A indicated or would not be available due  a call on 2/13/19 at 11:44 AM, ed leaving a message with the oreturn call and this call was 15 PM.  Shone call on 2/13/19 at 1:15 nager called. She explained at of her apartment building and would not be in the office.  Son 2/14/19 at 11:50 AM, the has not available by phone or as discussed with the orgonization was discussed with	G 9	50			

G 950 Continued From page 85 On 2/14/19 at 3:21 PM, it was observed that the owner, Employee C, received a text from the clinical manager. This text stated that the clinical manager was not available, the clinical manager just had a physical, severe UTI, chills, dehydration, and an elevated temperature of 101.5 degrees, and was on her way home.  During an interview on 2/15/19 at 10:35 AM, the office manager, Employee A, indicated the clinical supervisor would not be in today. She works Fridays at her other job.  During an interview on 2/18/19 at 10:25 AM, the clinical supervisor, Employee B, indicated working part-time at this agency 7 -12 hours a week including caring for patient #1 and #3. She	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
BLESSED HANDS HOME CARE AGENCY LLC  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (B 950 Continued From page 85 On 2/14/19 at 3:21 PM, it was observed that the owner, Employee C, received a text from the clinical manager was not available, the clinical manager just had a physical, severe UTI, chills, dehydration, and an elevated temperature of 101.5 degrees, and was on her way home.  During an interview on 2/15/19 at 10:35 AM, the office manager, Employee A, indicated the clinical supervisor would not be in today. She works Fridays at her other job.  During an interview on 2/18/19 at 10:25 AM, the clinical supervisor, Employee B, indicated working part-time at this agency 7 -12 hours a week including caring for patient #1 and #3. She			15K132	B. WING _		_	02/2	20/2019	
REGULATORY OR LSC IDENTIFYING INFORMATION)  G 950  Continued From page 85 On 2/14/19 at 3:21 PM, it was observed that the owner, Employee C, received a text from the clinical manager was not available, the clinical manager just had a physical, severe UTI, chills, dehydration, and an elevated temperature of 101.5 degrees, and was on her way home.  During an interview on 2/15/19 at 10:35 AM, the office manager, Employee A, indicated the clinical supervisor would not be in today. She works Fridays at her other job.  During an interview on 2/18/19 at 10:25 AM, the clinical supervisor, Employee B, indicated working part-time at this agency 7 -12 hours a week including caring for patient #1 and #3. She			GENCY LLC		4626 W WESTERN AVENUE	E			
On 2/14/19 at 3:21 PM, it was observed that the owner, Employee C, received a text from the clinical manager. This text stated that the clinical manager was not available, the clinical manager just had a physical, severe UTI, chills, dehydration, and an elevated temperature of 101.5 degrees, and was on her way home.  During an interview on 2/15/19 at 10:35 AM, the office manager, Employee A, indicated the clinical supervisor would not be in today. She works Fridays at her other job.  During an interview on 2/18/19 at 10:25 AM, the clinical supervisor, Employee B, indicated working part-time at this agency 7 -12 hours a week including caring for patient #1 and #3. She	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA		COMPLETION	
indicated the office manager would make the personnel assignments and coordinates referrals.  During an interview on 2/18/19 at 12 noon, the clinical supervisor, Employee B, indicated being very tired, ill, would be leaving the agency at this time, and would not be available.  Ensure that HHA employs qualified personnel CFR(s): 484.105(b)(1)(iv)  (iv) Ensure that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies.  This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure all home health aides completed a competency evaluation program and/ or were currently listed in good standing on the state nurse aide registry or home health aide registry for 4 of 15 records reviewed (#J, L, N, S) of staff who worked as home health aides for the		On 2/14/19 at 3:21 Powner, Employee C, clinical manager. The manager was not availust had a physical, sidehydration, and an 101.5 degrees, and will be deficed manager, Employer would not be ridays at her other justinear this ager including caring for point in the personnel assignment buring an interview of clinical supervisor, E part-time at this ager including caring for point in the personnel assignment buring an interview of clinical supervisor, E very tired, ill, would be time, and would not be Ensure that HHA emportant that HHA emportant in the personnel, including personnel qualification. This ELEMENT is not a saled on record reversible and/or were currently the state nurse aided registry for 4 of 15 residues.	M, it was observed that the received a text from the is text stated that the clinical ailable, the clinical manager severe UTI, chills, elevated temperature of was on her way home.  On 2/15/19 at 10:35 AM, the cloyee A, indicated the clinical be in today. She works ob.  On 2/18/19 at 10:25 AM, the mployee B, indicated working may 7 -12 hours a week satient #1 and #3. She manager would make the most and coordinates referrals.  On 2/18/19 at 12 noon, the mployee B, indicated being be leaving the agency at this per eleaving the agency at this per evaluable.  In 2/18/19 at 12 noon, the mployee B, indicated being be leaving the agency at this per evaluable.  In 2/18/19 at 12 noon, the mployee B, indicated being be leaving the development of the available.  In 2/18/19 at 12 noon, the mployee B, indicated being be leaving the agency at this per evaluable.  In 2/18/19 at 12 noon, the mployee B, indicated being be leaving the agency at this per evaluable.  In 2/18/19 at 12 noon, the mployee B, indicated being be leaving the agency at this per evaluable.  In 2/18/19 at 12 noon, the mployee B, indicated being be leaving the agency at this per evaluable.  In 2/18/19 at 12 noon, the mployee B, indicated being be leaving the agency at this per evaluable.  In 2/18/19 at 12 noon, the mployee B, indicated being be leaving the agency at this per evaluable.  In 2/18/19 at 12 noon, the mployee B, indicated being be leaving the agency at this per evaluable.  In 2/18/19 at 12 noon, the mployee B, indicated being be leaving the agency at this per evaluable.  In 2/18/19 at 10:35 AM, the clinical and the clinical at 10:35 AM, t						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		TE SURVEY MPLETED
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G 952	Aide Service" dated Home Health Aide. demonstrate or obset they are performed they are performed they are performed they are performed they are performing the tasks care."  2. A review of the performing dated 2108 shoulicensed Person are qualified for the sum accordance with a regulations and age.  3. A review of the performing dated Aides 1. Must have a program of at least 7 state and Federal results and Federal results and first part of the performing date and first part of the performing on the state health aide registry. Personal care workes signed by Employees	d: Dlicy titled "2.52 Home Health 2018 stated, "Duties of a The nurse or therapist erve the skills involved before by an HHA if the HHA does detraining or experience in prescribed in the plan of Dlicy titled "Screening and tated, "Licensed and nel will they demonstrate they position they are applying for at meet the minimum qualified applicable laws and ney job description." Dlicy titled "Employee I 2018 stated, "Home Health completed an aide training '5 hours which conforms to	G 9	952		
	During an interview owner indicated Emp	on 2/14/19 at 2:20 PM, the bloyee J wrote her				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 952	not.  5. A review of Employ of 5/12/16 and first pations of 5/12/16, evidenced the become registered as 3/7/17. The file evide checklist dated 5/17/11 homemaker competed. The home health aided 5/12/16 with a score of the file of the competed of the compe	yee L's File, with a hire date tient contact date of is home health aide did not a home health aide until need a personal care skills 6 and a companion/ney checklist dated 5/18/16. It competency test was dated of 87%.  Yee N's file, HHA, with d first patient contact date home health aide was listed he state nurse aide registry ry. The personnel file th aide/ job description are on 2/3/17. There was no in the record.  Yee S's file, HHA, with a hire first patient contact 3/5/17 amployee had been placed in 2/18/19 at 4:15 PM, the indicated this staff member registry as a home health	G 9			
G 960	Make patient and pers CFR(s): 484.105(c)(1		G 9	00		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 960	Continued From pa	ge 88	G 96	0	
	This ELEMENT is a Based on record reagency's clinical surand personnel assigned. The findings included the agency policy to Supervision" dated Administrator may a he/ she is qualified, qualified individual responsibility to suplimited to the major implement planned ensuring quality care During an interview clinical supervisor, part-time at this againcluding caring for B indicated that the the personnel assigned During an interview office manager indicated the personnel around the 25th of COn 2/8/19 at 11:10 she and the office in the daily operations indicated not being administrator who week.	itled "1.19 Agency 2018 stated, "The act as the clinical manager if or may appoint another who has authority and pervise clinical service but not functions listed below programs and services, re standards."  on 2/18/19 at 10:25 AM, the Employee B, indicated working ency 7 -12 hours a week patient #1 and #3. Employee office manager would make inments.  on 2/20/19 at 11:40 AM, the cated she and the owner I assignments for the patients			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '				SURVEY LETED
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G 960 G 964	Continued From page indicated April - May in administrative staff Coordinate referrals; CFR(s): 484.105(c)(3	2018 was a tense time with f in place.		960			
	Based on record revi agency's clinical man referrals for 1 of 1 age	t met as evidenced by: ew and interview, the ager failed to coordinate					
	he/ she is qualified, o qualified individual wh responsibility to super limited to the major fu	018 stated, "The t as the clinical manager if r may appoint another no has authority and rvise clinical service but not nctions listed below rograms and services,					
G1008	clinical supervisor, Er part-time at this agen	n 2/18/19 at 10:25 AM, the nployee B, indicated working cy 7 -12 hours a week atient #1 and #3. Employee ffice manager would	G10	008			
	patient accepted by the	ain a clinical record urrent information for every ne HHA and receiving home mation contained in the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		X3) DATE SURVEY COMPLETED		
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G1008	of practice, and be issuing orders for the and appropriate Hibbe maintained elect This CONDITION is Based on observatinterview, the agent followed their agent records contained at 12 records reviewerensure clinical records end and dated amanner. (see G 1012); and fisigned and dated amanner. (see G 102) The cumulative efferesulted in the homensure the provisions afe environment for participation: 484.1 Records.  Regarding G 1008,  1. The agency policity contents dated 20 maintains a confider patient / client admit data includes signed admission and clinic day the service is releast weekly All ribe completed and in within 14 days of seconds.	rd documentation standards available to the physician(s) he home health plan of care, IA staff. This information may pronically. Is not met as evidenced by: ion, record review and cy failed to ensure they cy policy and that the clinical accurate information for 2 of comparison of care are alled to ensure a physician plan of care within a timely each).  In the condition of the condition: Clinical condition: Clinical condition: Clinical condition of the findings include:  The findings include:  The identifying med, timed and dated cal notes that are written the endered and incorporated at equired documentation must in the patient / client record	G100	8				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED	
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G1008	visit record showing visited patient #4 on 4/19/18, 4/20/18 fror completed tasks incompleted tasks. Anothe Employee J, HHA had 18/18, 4/19/18, 4/2 PM and completed chair, assist with drareminders, and light records showed the time and did the sar On 2/11/19 at 2:28 Fone aide is here at a changing shifts.  On 2/14/19 at 12:20 always working by hemployees present. Employee O.  On 2/14/19 at 2 PM, difference between personal service recagency did not dupling A review of a plan or period of 1/3/19 - 3/3 from the physician of this document show 2/7/19.	Ilowing:  4 evidenced an aide weekly Employee O, HHA had 14/16/18, 4/17/18, 4/18/18, m 11 AM - 4 PM and Iluding shower, complete assist with dressing, skin check pressure areas and ier aide visit record evidenced ad visited patient #4 on 20/18, 4/21/18 from 11 AM - 4 bed bath, bath assist in a ressing, skin care, medication housekeeping. These aides visited at the same ine tasks.  PM, patient #4 indicated only a time unless they are  PM, Employee J indicated rerself and without other She indicated not knowing  The owner explained the shome health aide records and bords and indicated the	G10	08			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		40	TREET ADDRESS, CITY, STATE, ZIP CODE 626 W WESTERN AVENUE SOUTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G1008	plan of care with patie was superimposed or 3. A review of clinica made with Employee 11/14/18, 11/15/18, a  During a phone intervipatient #10 indicated aide come into the hor Required items in clin CFR(s): 484.110(a)(1)  The patient's current including all of the as recent home health a plans of care, and phora This ELEMENT is not Based on record reviagency failed to ensure plans of care for 1 of Findings include:  1. The agency policy Records" dated 2018 requirements for main storing paper medica for electronic records meet all statutory, regrequirements for clinic business purposes. Trecord, to be a legal resame requirements a	anted the signature on last ent #4 was an error. This in paper and was a mistake.  If record #10 evidenced visits O on 11/12/18, 11/13/18, and 11/16/18.  Ariew on 2/15/19 at 9:40 AM, the/ she never had a male ome, including Employee O. thical record  Comprehensive assessment, sessments from the most dmission, clinical notes, ysician orders; and the trace of the trace		0012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED	
		15K132	B. WING _			2/20/2019	
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		STREET ADDRESS, CITY, STATE, ZIP CO 4626 W WESTERN AVENUE SOUTH BEND, IN 46619	•		
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G1012	2. The agency policy Maintenance" dated shall maintain clinical which contain the phyrequired], clinical and pertinent information documentation are mand in accordance w procedure"  3. A review of an aud #2 on 2/15/19 evidencertification period of created and saved of was not completed in took place without the completed and sent to physician.  4. A review of record evidenced the plan of period of 1/24/19 - 3/3 saved on 2/7/19 and 2/7/19. The plan of timely manner and caplan of care being cophysician for approvation of 1/3/19 - 3/3 or faxed to the physician for an aud #4 evidenced the plan of taken place during the office manager in the office manager in the contained which is a place of 1/3/19 in the office manager in the office manager in the contained which is a place of the physician for manager in the office manager in the contained which is a place of the physician for manager in the office manager in the contained which is a place of the physician for manager in the office manager in the contained which is a place of the physician for manager in the office manager in the office manager in the contained which is a place of the place of the physician for approved the office manager in the office manager in the contained which is a place of the place	wititled "Clinical Record 2018 stated, "The agency I records for all patients ysician's plan of treatment [if it progress notes, and other. Entries to patient record hade only y authorized staff ith organizational policy and dit trail document for patient fixed the plan of care for the it 1/10/19 - 3/10/19 was in 2/7/19. The plan of care in a timely manner and care in a timely manner and care in an approved by the it is a constant of the physician on care was not completed in a fare took place without the impleted and sent to the indicated the recently created in a care for the certification (19 was not created, saved, cian until 2/7/19. Care had its time.  We on 2/15/19 at 11:15 AM, indicated the recently created ent #2, #3, and #4 were not	G10	12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		15K132	B. WING			02/	20/2019
	ROVIDER OR SUPPLIER  HANDS HOME CARE A	GENCY LLC		46	TREET ADDRESS, CITY, STATE, ZIP CODE 626 W WESTERN AVENUE OUTH BEND, IN 46619		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G1024 G1024	appropriately authent Authentication must in (occupation), or a secunique identifier, of a reviewed and approved This STANDARD is represented a passed on record reviagency failed to ensure of care within a timely reviewed. (#5)  Findings include:  The agency policy title Contents dated 2018 A verbal or written phyrior to starting care are renewed as necessar months for patients for patients for patients for the certification and interview of the certification of the	ation. gible, clear, complete, and icated, dated, and timed. nclude a signature and a title cured computer entry by a primary author who has ed the entry. not met as evidenced by: few and interview, the re a physician signed a plan of manner for 1 of 12 records  ed "2.43 Clinical Record 8 stated, "Physician orders ysician order is obtained These orders are to be ry and a minimum of every 2 clients receiving skilled care  on 2/13/19 failed to n's signature on the plan of on period of 9/23/18 -	G1 G1				