

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000000	<p>This visit was for a state hospice relicensure survey.</p> <p>Survey Dates: October 8 through October 10, 2013.</p> <p>Facility #: 3611</p> <p>Medicaid Vendor #: 200440920.</p> <p>Total unduplicated admissions: 67.</p> <p>Surveyor: Janet Brandt, RN, PHNS Ingrid Miller, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 15, 2013</p>	S000000		

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S000523	<p>418.54(b) TIMEFRAME FOR COMPLETION OF ASSESSMENT The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24. Based on clinical record review, interview, and policy review, the agency failed to ensure the initial and comprehensive assessment was completed within 5 days in 1 of 6 records (#3) reviewed with the potential to affect all the 13 patients of the hospice.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. Clinical record #3, start of care 5/3/13, evidenced an initial comprehensive assessment completed on 5/9/13 by Employee J, Masters of Social Work. 2. The hospice policy titled "Policy: Assessment guidelines: Psychosocial, Volunteer, Bereavement, and Spiritual Assessment" with an effective date of 12/8/08 stated, "The hospice social worker completes a Psychosocial, Volunteer, Bereavement, and Spiritual Assessment within 5 days of the hospice admission." 3. On 10/10/13 at 1:45 PM, Employee B, the clinical manager and registered nurse, 	S000523	Tag number 0523 1. Staff will be in serviced and given Blue Skies Hospice policies for comprehensive and initial assessment to be completed within 5 day of hospice admission.2. To prevent the deficiency from reoccurring all newly admitted hospice patient's charts will be reviewed by the clinical manager within 5 days after admission.3. The responsible person will be the administrator.4. Date Deficiency corrected by 10/25/13	10/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the comprehensive assessment for record #3 was not completed within the 5 days as required.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013	
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED				STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000543	<p>418.56(b) PLAN OF CARE All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.</p> <p>Based on skilled nursing facility documentation review, observation, interview, clinical record review, and policy review, the hospice failed to ensure the care provided to the patient followed the written plan of care for 2 of 6 records reviewed (Clinical record #4 and #5) with the potential to affect all 13 active patients of the hospice.</p> <p>Findings</p> <p>1. Clinical record #4, start of care 9/19/11, failed to include an order for honey thickened liquids despite an order in the skilled nursing facility record of this patient dated 6/25/13 for honey thickened liquids.</p> <p>a. On 19/9/13 at 10:05 AM, a sign in patient #4's room above the patient's bed stated, "[Patient] is on thickened liquids. Please make sure if you give him liquid, it is thickened."</p>	S000543	<p>1. An order for honey thickened liquids for clinical record number 4, and an order for urinary catheterization, urinalysis, and urine culture and sensitivity for clinical record 5 were written and placed in the 2 hospice patient charts in the hospice plan of care. Staff will be in-serviced in obtaining orders from facility charts and updating plan of care.2. To prevent the deficiency from reoccurring all orders and skilled care facility charts will be reviewed at biweekly IDT to ensure compliance.3. The responsible person will be the clinical manager4. Date deficiency corrected 10/25/13</p>	10/25/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>b. On 10/10/13 at 1:55 PM, Employee B, clinical manager, indicated the hospice plan of care failed to include an order for the honey thickened liquids for patient #4.</p> <p>2. Clinical record #5, SOC 6/9/11, failed to include an order for a urinary catheterization and urinary analysis and culture and sensitivity despite an order in the skilled nursing facility record of this patient dated 9/4/13 that stated, "Please obtain u/a / C & S [urinary analysis culture and sensitivity] may straight cath [catheterize] if needed, per family request r/o [rule out] uti [urinary tract infection]." The order in the skilled nursing facility record was written by Employee C, Registered Nurse, an employee of the hospice. However, this order was not part of the written plan of care at the hospice.</p> <p>a. A nurse note written by Employee C, Registered Nurse on 9/6/13 stated, "Preliminary urine culture show 10 - 50,000 gram neg [negative], awaiting culture results ... I called [physician's nurse practitioner] and received order to obtain u / a ... to culture. May straight cath if needed. Instructed staff on order." There was no order noted in the hospice record.</p> <p>b. On 10/9/13 at 2:55 PM, Employee</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>B, the clinical manager, indicated the u/a order was not in the clinical record.</p> <p>3. The agency policy titled "Plan of Care" with a date of 12/2/08 stated, "To provide direction to hospice personnel providing direct patient care ... The hospice updates the plan of care as often as the condition of the patient indicates ... the plan of care is part of the clinical record."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S000545	<p>418.56(c) CONTENT OF PLAN OF CARE The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:</p> <p>Based on skilled nursing facility documentation review, observation, interview, clinical record review, and policy review, the hospice failed to ensure the plan of care identified all the services and treatments to meet the patient's needs for 2 of 6 records (Clinical record #4 and #5) with the potential to affect all 13 active patients of the hospice.</p> <p>Findings include:</p> <p>1. Clinical record #4, start of care 9/19/11, failed to include an order for honey thickened liquids despite an order in the skilled nursing facility record of this patient dated 6/25/13 for honey thickened liquids.</p> <p>a. On 19/9/13 at 10:05 AM, a sign in patient #4's room above the patient's bed</p>	S000545	<p>1. The plan of care for clinical record number 4 was updated to include honey thickened liquids, and the plan of care for clinical record number 5 was updated to include urinary catheterization, urinalysis and urine culture and sensitivity. Staff will be in-serviced and given copies of Blue Skies Hospice policy on plan of care.2. To prevent the deficiency from reoccurring, the plan of care identifies all services and treatments ordered and will be reported at IDT.3. The responsible person will be the clinical manager4. Date completed 10/25/2013</p>	10/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>stated, "[Patient] is on thickened liquids. Please make sure if you give him liquid, it is thickened."</p> <p>b. On 10/10/13 at 1:55 PM, Employee B, clinical manager, indicated the hospice plan of care failed to include an order for the honey thickened liquids for patient #4.</p> <p>2. Clinical record #5, SOC 6/9/11, failed to include an order for a urinary catheterization and urinary analysis and culture and sensitivity despite an order in the skilled nursing facility record of this patient dated 9/4/13 that stated, "Please obtain u/a / C & S [urinary analysis culture and sensitivity] may straight cath [catheterize] if needed, per family request r/o [rule out] uti [urinary tract infection]." The order in the skilled nursing facility record was written by Employee C, Registered Nurse, an employee of the hospice. However, this order was not part of the written plan of care at the hospice.</p> <p>a. A nurse note written by Employee C, Registered Nurse on 9/6/13 stated, "Preliminary urine culture show 10 - 50,000 gram neg [negative], awaiting culture results ... I called [physician's nurse practitioner] and received order to obtain u / a ... to culture. May straight cath if needed. Instructed staff on order." There was no order noted in the hospice</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>record.</p> <p>b. On 10/9/13 at 2:55 PM, Employee B, the clinical manager, indicated the u/a order was not in the clinical record.</p> <p>3. The agency policy titled "Plan of Care" with a date of 12/2/08 stated, "To provide direction to hospice personnel providing direct patient care ... The hospice updates the plan of care as often as the condition of the patient indicates ... the plan of care is part of the clinical record."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S000546	<p>418.56(c)(1) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (1) Interventions to manage pain and symptoms.</p> <p>Based on clinical record review, policy review, and interview, the hospice failed to ensure the written plan of care included all services necessary for the palliation and management of pain and symptoms for 1 of 6 clinical records (#4) reviewed with the potential to affect all the 13 active hospice's patients.</p> <p>Findings</p> <p>1. Clinical record #4, start of care 9/19/11, evidenced a nurse visit note dated 9/23/11 completed by Employee C, Registered Nurse (RN), with documentation that stated, "Pain ... Abscess to R [right] axilla tender to touch." There was no documentation that a pain rating had been completed.</p> <p>2. The hospice policy titled "Pain Management" with an effective date of 12/2/08 stated, "Pain management and symptom control is the foundation of good Hospice Care. Care is directed to optimize the patient's comfort and dignity</p>	S000546	<p>1. Staff will be in-serviced on symptom management and documentation including a pain rating using an appropriate pain rating scale. Staff will be in-serviced and given copies of Blue Skies Hospice pain management policy.2. To prevent reoccurrence and to ensure compliance, pain rating and use of appropriate pain rating scale will be reported at biweekly IDT.3. The responsible person will be the clinical manger4. Date deficiency will be completed 10/25/13</p>	10/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>through appropriate treatment of secondary symptoms and aggressively managing these symptoms ... Procedure: Management RN ... Pain rating is to be documented on progress note after each RN visit."</p> <p>3. On 10/10/13 at 1:50 PM, Employee B, the clinical manager and RN, indicated clinical record #4 failed to include a completed pain rating at the documented visit.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000550	<p>418.56(c)(5) CONTENT OF PLAN OF CARE [The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:] (5) Medical supplies and appliances necessary to meet the needs of the patient.</p> <p>Based on clinical record and policy review and interview, the hospice failed to ensure each patient had a Plan of Care that included medical supplies and appliances necessary to meet the patient's needs for 1 of 6 (#1) clinical records reviewed with the potential to affect all patients of the hospice.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The plan of care for patient # 1, for the certification period 8-22-13 to 10-22-13, listed a AAP overlay for the mattress as equipment. Employee B, on 10-8-13 2:00 PM, Employee B indicated the plan of care and equipment listed was current to the patient as far as employee B was aware. On home visit observation on 10-8-13 at 4:55 PM, patient #1 was observed to be lying in a low bed with a mat placed next to the bed, the patient also had a bed alarm. 	S000550	<ol style="list-style-type: none"> The plan of care for clinical record number one was updated to include the description of equipment used low bed with a mat next to it and alarms to ensure patient safety. Staff will be in-serviced on physician orders and given copies of Blue Skies Hospice policy on physician orders. To prevent reoccurrence and to ensure compliance, updating the plan of care to include a description of equipment used will be compiled and reported at biweekly IDT. The responsible person will be the clinical manager. Date deficiency corrected 10/25/13 	10/25/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>At 5:00 PM 10/8/13, Employee C indicated the patient had a history of falls and decreased cognitive function with decreased safety awareness and that was the rationale for the low bed, mat next to the bed, and bed alarm. Employee C indicated staff from the hospice attended the facility care plan meetings routinely and was aware the facility care plan listed the low bed, mat, and alarms as being current to the patient, but the hospice plan of care had not been updated to reflect the low bed, alarms, or mat.</p> <p>3. The policy titled "Physician Orders" #704, effective 12-2-18, indicated the contents of the patient plan of care was to include a description of any equipment used in the provision of care and any environmental precautions that affected the implementation of the plan of care.</p> <p>On 10-9-13 at 9:00 AM, employee B indicated Employee C may not have updated the plan of care to reflect the low bed, mat, and alarms in a timely manner.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

S000579	<p>418.60(a) PREVENTION</p> <p>The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.</p> <p>Based on document review, policy review, interview, and observation, the hospice failed to ensure employees (I) providing direct patient care followed standard infection control practices at 1 of 2 home visits observed (patient #4) and supplies were clean, not opened, and not expired during 1 of 1 observation of inpatient facility storage areas with the potential to affect all 13 current patients and future patients of the hospice.</p> <p>Findings</p> <p>1. At a home visit observation on 10/9/13 at 10:05 AM, Employee I, Hospice Aide, was observed to remove patient #4's soiled depends patient #4. After cleaning patient #4's rectal area with wipes, employee I discarded the soiled wipes and depends and removed her soiled gloves and donned new gloves without washing hands with soap and water or antiseptic hand gel. Then she returned to the patient and washed the patient's arms and upper body.</p> <p>A. On 10/9/13 at 3:20 PM, Employee</p>	S000579	<p>1. All expired and damaged supplies were removed from storage area. Staff members were in-serviced on hand washing with return demonstration. Staff members were in-serviced in keeping safe storage areas clean and orderly. Blue skies Hospice Policies on hand washing and maintaining clean and orderly storage areas given to staff. 2. To prevent reoccurrence staff members will be observed during supervisory visits. Storage areas are checked monthly for expired supplies and damaged supplies which are discarded as needed. A log will be kept and monitored by administrator quarterly. 3. The responsible person will be the clinical manager. 4. Date deficiency completed 10/25/13</p>	10/25/2013
---------	--	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013	
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED				STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>B, the clinical manager, indicated handwashing should occur after gloves are removed.</p> <p>B. The agency policy titled "Handwashing" with an effective date of 12/2/08 stated, "Personnel providing care / service in the home setting will wash their hands ... before and after gloves are used."</p> <p>2. On 10/10/13 at 2:55 PM, the inpatient hospice facility was observed to have two patient rooms. A patient supply storage area of the north patient room was observed to have an opened package of Toothette single use oral swabs with 11 of 20 swabs left in the package. There also was an opened box of disposable wipes. In the storage supply closet located in a nearby hallway was a Foley Catheter tray which had expired on October 2003 and an unopened urinary leg bag with an expiration date of 7/12. There was also adult nasal cannula tubing that had been opened and was still in the packaging. Also, a box of opened Hypafix wound covering was observed in an opened box with a brown discoloration along the bottom half of the box.</p> <p>A. On 10/10/13 at 3:15 PM, Employee A, administrator, and Employee B, the clinical manager,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated the supplies should have been discarded.</p> <p>B. The agency document titled "Safety Checklist" with no effective date stated, "Storage areas are kept clean and orderly."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S000626	<p>418.76(g)(2) HOSPICE AIDE ASSIGNMENTS AND DUTIES (2) A hospice aide provides services that are:</p> <ul style="list-style-type: none"> (i) Ordered by the interdisciplinary group. (ii) Included in the plan of care. (iii) Permitted to be performed under State law by such hospice aide. (iv) Consistent with the hospice aide training. <p>Based on observation, interview, and review of agency documents, the hospice failed to ensure the 1 of 1 hospice aide (I) observed provided services consistent with the hospice aide training with the potential to affect any of the hospice patients cared for by this employee.</p> <p>Findings</p> <p>1. On 10/9/13 at 10:05 AM, Employee I, Hospice Aide, was observed to roll patient #4 to his / her right side while the patient was lying in bed and receiving a bed bath. Employee I was observed to use her left hand to roll the patient and pull off the patient's depends with her right hand. The patient's body was not aligned from head, neck, and back area while Employee I positioned the patient by pushing on the patient's right hip. This caused the patient's back to bend forward towards the patient's knees while the upper back was flat on the bed. This movement pulled the rest of the body forward after the right hip had already</p>	S000626	<p>1. Staff members were in-serviced on body mechanics, range of motion and positioning. Visit was made with employee 1 during care for patient number 4. Positioning, range of motion, and body mechanics were demonstrated by Blue Skies Hospice HHA , and RN was returned demonstrated with 100 % accuracy by employee number 1.2. To prevent reoccurrence body mechanics, positioning and range of motion will be observed during onsite HHA supervisory visits and documented and reported to IDT.3. The responsible person will be the clinical manager.4. Date deficiency completed 10/25/13</p>	10/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>gone forward. After the bath and linen change, Employee I went to the head of the bed and pulled out the bed from the wall to pull the patient up in bed. She proceeded to pull the patient up in bed by pulling on the bottom sheet under the patient with each of her hands on each side of the patient's head and neck and dragging the patient to the top of the bed by pulling on this sheet.</p> <p>2. The agency inservice document titled "Range of Motion and positioning" with no effective date stated, "Some basic rules of positioning ... when moving a client, lift rather than drag. Bed positioning tips: position the spine in alignment."</p> <p>3. Employee I's personnel file evidenced employee I had attended an inservice on 7/3/13 over the range of motion and position and taken a test on 7/3/13 with a score of 90%.</p> <p>4. On 10/9/13 at 3:20 PM, Employee B, the clinical manager, indicated that Employee I should keep the patient's body in alignment while turning the patient and positioning the patient in bed and should not move the patient up in bed by dragging the patient up in bed with the sheets.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013	
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED				STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000701	<p>418.106(f)(1) USE & MAINTENANCE OF EQUIPMENT & SUPPLIES</p> <p>The hospice must ensure that manufacturer recommendations for performing routine and preventive maintenance on durable medical equipment are followed. The equipment must be safe and work as intended for use in the patient's environment. Where a manufacturer recommendation for a piece of equipment does not exist, the hospice must ensure that repair and routine maintenance policies are developed. The hospice may use persons under contract to ensure the maintenance and repair of durable medical equipment.</p> <p>Based on observation, interview, and review of agency documents, the hospice failed to have a routine preventative maintenance program in place for 1 of 1 hospice with the potential to affect all patients who utilize the inpatient hospice.</p> <p>Findings</p> <p>1. Review of clinic documents failed to evidence a preventative maintenance program was in place for all durable medical equipment found in the inpatient hospice facility.</p> <p>2. On 10/10/13 at 2:55 PM, two patient rooms in the inpatient hospice facility were observed to each contain an oxygen concentrator.</p>	S000701	.1. All durable medical equipment was given preventative maintenance according to manufacturing guidelines. A preventative maintenance policy was developed and implemented. Staff was in-serviced on the new policy.2. To prevent reoccurrence all preventative maintenance logs will be evaluated quarterly to ensure compliance.3. The responsible person will be the administrator.4. Date completed 11/30/13 no patient will be admitted inpatient until corrected.	10/25/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	3. On 10/10/13 at 4:40 PM, the administrator indicated there were no documents available at this time to show that a preventative maintenance program was in place to monitor oxygen equipment in patient rooms.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013	
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED				STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000730	<p>418.110(f) PATIENT ROOMS</p> <p>(1) The hospice must ensure that patient rooms are designed and equipped for nursing care, as well as the dignity, comfort, and privacy of patients.</p> <p>(2) The hospice must accommodate a patient and family request for a single room whenever possible.</p> <p>(3) Each patient's room must-</p> <p>(i) Be at or above grade level;</p> <p>(ii) Contain a suitable bed and other appropriate furniture for each patient;</p> <p>(iii) Have closet space that provides security and privacy for clothing and personal belongings;</p> <p>(iv) Accommodate no more than two patients and their family members;</p> <p>(v) Provide at least 80 square feet for each residing patient in a double room and at least 100 square feet for each patient residing in a single room; and</p> <p>(vi) Be equipped with an easily-activated, functioning device accessible to the patient, that is used for calling for assistance.</p> <p>(4) For a facility occupied by a Medicare-participating hospice on December 2, 2008, CMS may waive the space and occupancy requirements of paragraphs (f)(2)(iv) and (f)(2)(v) of this section if it determines that-</p> <p>(i) Imposition of the requirements would result in unreasonable hardship on the hospice if strictly enforced; or jeopardize its ability to continue to participate in the Medicare program; and</p> <p>(ii) The waiver serves the needs of the patient and does not adversely affect their health and safety.</p> <p>Based on observation and interview, the</p>	S000730	1. The call light system was repaired and batteries were replaced and the system was	11/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>hospice failed to ensure the inpatient rooms had closet space that provided security and privacy for clothing and personal belongings and failed to have a functional call system for patients to use to call for staff for 1 of 1 inpatient hospice units with the potential to affect all patients of the agency who utilize the inpatient hospice.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation of the 2 hospice inpatient rooms on 10-10-13 at 9:00 AM failed to evidence any closet space for the secure storage of clothing and personal belongings. The call light in both patient rooms was non functional. 2. In an interview with Employee B on 10-10-13 at 3:15 PM, Employee B indicated that none of the rooms on the inpatient unit of the hospice had a closet for secure storage for clothing and personal belongings. Employee B indicated the call light system would need further investigation, but the call light system was not functional at the time of survey. 3. In an interview with Employee A on 10-10-13 at 3:18 PM, Employee A indicated that none of the inpatient rooms had closets for secure storage of clothing 		<p>tested to ensure proper working condition. Locks will be placed on the patient cabinets to ensure privacy.2. To prevent reoccurrence batteries in the call light system will be replaced every 6 months and as needed and will be included in the routine maintenance policy. Patient cabinets will be locked to ensure privacy and a master key for each patient cabinet will be given to the patient or family member and another key will be placed in the locked narcotic cabinet to ensure patient privacy.3. The responsible person will be the administrator.4. Date deficiency completed 11/30/13 no patients will be taken in the inpatient unit until completed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	and personal belongings. Employee A further indicated the call light system for the patients to notify the nurse of a need for assistance consisted of a necklace worn by the nurse that would light up and sound if a patient pressed the button on their call device. Employee A indicated the need to locate the necklace the nurse would wear and make sure the call light button(s) were in working order. Employee A agreed the call light system was non functional at the time of survey.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013	
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED				STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000732	<p>418.110(h) PLUMBING FACILITIES The hospice must-</p> <p>(1) Have an adequate supply of hot water at all times; and (2) Have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients.</p> <p>Based on interview and observation, the hospice failed to ensure the inpatient hospice had plumbing fixtures with control valves that would automatically regulate the temperature of the hot water used by patients for 1 of 1 hospice inpatient units with the potential to affect all patients of the inpatient unit of the hospice.</p> <p>Findings include:</p> <p>1. Observation of the inpatient hospice facility plumbing fixtures on 10-10-13 at 11:00 AM failed to evidence any control valves to control the temperature of the hot water used by patients.</p> <p>2. In an interview with employee B on 10-10-13 at 11:00 AM, employee B indicated the agency inpatient facility plumbing fixtures did not have control valves to regulate the temperature of the hot water used by patients. There was no documentation of that indicated water temperatures were monitored. Employee B indicated the cold water tap could be</p>	S000732	<p>1. Plumbing equipment will be replaced with fixtures that have temperature control valves to monitor temperature. When patients are housed in the inpatient facility daily temperature logs will be maintained for plumbing fixtures in the patient bathroom and in the kitchen.2. To prevent reoccurrence a daily temperature will be recorded for plumbing fixtures in the kitchen and patient bathrooms when patients are housed. The administrator will evaluate temperature logs quarterly to ensure compliance3. The responsible person will be the clinical manager4. Date deficiency will be corrected 11/30/13 no patients will be admitted to the inpatient unit until corrected.</p>	11/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>turned on to regulate the temperature of the hot water coming from the hot water tap and that was how the water temperature was regulated.</p> <p>3. In an interview with employee A on 10-10-13 at 1:30 PM, employee A indicated the agency inpatient facility plumbing fixtures did not have control valves to regulate the temperature of the hot water used by patients.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S000734	<p>418.110(j) SANITARY ENVIRONMENT The hospice must provide a sanitary environment by following current standards of practice, including nationally recognized infection control precautions, and avoid sources and transmission of infections and communicable diseases.</p> <p>Based on document review, observation, and interview, the hospice failed to ensure patient supplies were checked for expiration dates and disposed of after their expiration dates and patient supplies were discarded when opened or soiled in 1 of 1 inpatient hospice observations with the potential to affect any patients cared for in the inpatient hospice facility.</p> <p>Findings</p> <p>1. On 10/10/13 at 2:55 PM, the inpatient hospice facility was observed to have two patient rooms. A patient supply storage area of the north patient room was observed to have an opened package of Toothette single use oral swabs with 11 of 20 swabs left in the package. There also was an opened box of disposable wipes. In the storage supply closet located in a nearby hallway was a Foley Catheter tray which had expired on October 2003 and an unopened urinary leg bag with an expiration date of 7/12. There was also adult nasal cannula tubing that had been</p>	S000734	<p>1. All expired and opened supplies discarded. Staff will be in-serviced on maintaining storage areas clean and neat. A copy of Blue Skies Hospice policy on safety check list which includes maintaining storage areas clean and orderly will be given to all staff members. Monthly checks of the storage areas will be performed by Blue Skies staff and expired and damaged supplies will be discarded.2. To prevent reoccurrence Blue Skies Hospice will not accept donation of any supplies from outside sources. And the clinical manger will monitor storage areas monthly to ensure compliance3. The responsible person will be the clinical manager4. Date deficiency completed 10/25/13</p>	10/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>opened and was still in the packaging. Also, a box of opened Hypafix wound covering was observed in an opened box with a brown discoloration along the bottom half of the box.</p> <p>2. On 10/10/13 at 3:15 PM, Employee A, administrator, and Employee B, the clinical manager, indicated the supplies should have been discarded.</p> <p>3. The agency document titled "Safety Checklist" with no effective date stated, "Storage areas are kept clean and orderly."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S009997	<p>IC 16-28-13-4 Aide Registry Sec. 4(a) Except as provided in subsection (b), a person who:</p> <p>1) operates or administers a health care facility; or</p> <p>2) operates an entity in the business of contracting to provide nurse aides or other unlicensed employees for a health care facility;</p> <p>shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department...</p> <p>b) A health care facility is not required to apply for the state nurse aide registry report ... required by subsection (a) if the health care facility contracts to use the services of a nurse aide or other unlicensed employee who is employed by an entity in the business of contracting to provide nurse aides or other unlicensed employees to health care facilities.</p> <p>Based on personnel file, document, and policy review and interview, the hospice failed to ensure staff furnishing hospice aide services had current registration on the Indiana nurse aide registry for 1 of 1 active hospice aide personnel files reviewed (I) with the potential to affect all the patients who received hospice aide services.</p> <p>Findings include:</p> <p>1. Personnel file I included an aide registration that expired 6/30/10.</p>	S009997	<p>1. All current HHA were updated on the HHA registry. Staff will be in-serviced on the importance of maintaining licensure/certification.2. To prevent reoccurrence HHA certification expiration date will be put in the EMR system to ensure notification for future expiration of certification. A quarterly EMR report will be completed by clerical staff and reported to clinical manager.3. The responsible person will be the clinical manager.4. Date deficiency corrected 10/25/13</p>	10/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151581	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013
NAME OF PROVIDER OR SUPPLIER BLUE SKIES HOSPICE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2714 169TH ST HAMMOND, IN 46323		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>On October 10, 2013, at 12:05 PM, employee A indicated personnel file for employee I, the aide registration appeared to have expired as of 6-30-2010. Employee A indicated being unaware the aide registration had expired for Employee I on 6-30-10 according to the "Indiana OnLine Licensing" website.</p> <p>2. The document titled "Blue Skies Hospice-Home Health Aide Job Description", undated, states, "Required knowledge and skills and abilities - Education and Experience: Currently on the Home Health Aide Registry as having satisfactorily completed training course and or competency testing which qualifies him/her to do home health aide work in a Medicare certified hospice."</p>				