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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K076	A. BUILDING 00 B. WING	09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEAVEN SENT HOME HEALTH CARE LLC	10484 N STATE ROAD 13 ELWOOD, IN 46036

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0000 Bldg. 00	This was a second post condition revisit (PCR) for the federal home health recertification survey origionally completed on January 16, 2019. Survey Date: September 5, 6; 2019 Facility Number: 012612 Provider Number: 15K076 Unduplicated Census: 72 Current Census: 44 Sample: Record Review With Home Visits: 1 Record Review Without Home Visits: 3 Total Home Visits: 1 Total Records Reviewed: 4 During this survey, two conditions of participation, twenty standard level deficiencies were found corrected, seven standard level deficiencies were re-cited. Heaven Sent Home Health LLC continues to be precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning January 16, 2019 to January 16, 2021 for being found out of compliance with the Conditions of Participation 42 CFR 484.50 Patient Rights, 484.55 Comprehensive Assessment of Patients, 484.60 Careplanning, coordination, quality of care, 484.75 Skilled Professional Services, and 484.110 Clinical records.	G 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 0528 Bldg. 00	Based on record review, and interview, the registered nurse (RN) failed to ensure that the comprehensive assessment contained all information regarding the patient's current health status for 1 of 4 records (#1). Findings include: An agency policy dated 1/29/17 titled "Guidelines for assessment," Policy # 2.05 stated "... Initial comprehensive assessment: 1. The initial assessment form is utilized by the RN for the initial evaluation and / or assessment in order to: ... Determine the need for home care and services and the type of care and services to be provided ... will include ... supplies and equipment required ... pertinent physical findings ... equipment needs ... Reassessment: ... The reassessment process is ongoing throughout the client's contact with [agency]. Each client is reassessed to determine the client's response to care or services. Reassessment occurs: ... Every 60 days when the client is receiving services." An agency policy dated January 2018 titled "RN clinical Manager," Policy # HC-105 stated "... Essential functions ... Performs comprehensive assessments of client status, including physical ... parameters ...." The clinical record of patient #1 was reviewed on 9/5/19 and indicated a start of care date of 6/9/15. The record contained a plan of care for the certification period of 7/18/19-9/15/19 that indicated a skilled respite nursing frequency of "20 hrs [hours] mo [month] used when wife has to	G 0528	G-0528 Assistant clinical director retrained/In-serviced on Completing a comprehensive assessment The RN whom completed this assessment which failed to contain all of the patients current health status as sited in finding was counseled in writing and retrained to include all information regarding the patients current health status. All patients cited at survey have been corrected 10% of all clinical charts will be audited quarterly to adhere to this deficiency and any adverse effect will be reported to the QAPI Clinical Manager/Administrator will be responsible for monitoring these corrective actions and to ensure this deficiency is corrected and will not recur	10/04/2019

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	be gone on Thursdays ... patient is vent dependent has respiratory distress and choking episodes when eating .... " The record failed to evidence the current respiratory status as evidenced by: The recertification comprehensive assessment completed on 7/15/19 was blank under the respiratory status. It failed to identify the patient's breath sounds, cough, if was a smoker, sputum, if had orthopnea, hemoptysis, or cyanosis, or tracheotomy information including size. Under DME [durable medical equipment] and supplies it stated "vent O2[oxygen] supplies." The comprehensive assessment failed to evidence the needs of the patient and tasks the nurse was to complete while in the home, the type of ventilator, ventilator settings, or choking episodes. During an interview on 9/5/19 at 11:10 AM, the director of nursing stated she was leaving the office to see a patient (Patient #1). She stated the patient is "a vent patient," and the last person alive that came off the iron lung. She also stated "he is respite only."			
G 0574 Bldg. 00	Based on record review and interview, the agency failed to ensure the plan of care (POC) included all pertinent treatments, orders, and goals in 2 of 4 records reviewed. (#1, 2). Findings include: 1. An agency policy dated 2/13/19 titled "Physicians plan of treatment," Policy #2.18	G 0574	G-0574 Clinical Director has educated/in-serviced nursing staff on G574 including all pertinent diagnoses, treatments and measurable outcomes assessments for accurate documentation. All records cited at survey have been corrected.	10/04/2019

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	stated "... A physician's plan of treatment must be signed by the physician and in the chart within 30 days after admission to [agency] and must include: ... The type and frequency of services needed ... specific orders ... necessary medical supplies and equipment ...." 2. An agency policy dated 6/28/19 titled "Clinical management and assignments," Policy # 2.10 stated "... Essential unctions ... Develops and / or follows an individualized plan of care ...." 3. The clinical record of patient #1 was reviewed on 9/5/19 and indicated a start of care date of 6/9/15. The record contained a plan of care for the certification period of 7/18/19-9/15/19 that indicated a skilled respite nursing frequency of "20 hrs [hours] mo [month] used when wife has to be gone on Thursdays ... patient is vent dependent has respiratory distress and choking episodes when eating .... " The plan of care failed to evidence the needs of the patient with the tasks (orders) the nurse was to complete while in the home, the type of ventilator, ventilator settings, wound care orders, a frequency that reflects the needs of the patient, and goals for dyspnea and the wound. The recertification comprehensive assessment completed on 7/15/19 was blank under the respiratory status. Under DME [durable medical equipment] and supplies it stated "vent O2[oxygen] supplies." The integumentary status stated the patient had a pressure ulcer on the sacrum and the wife completed a wet to dry dressing daily. 4. The clinical record of patient #2 was reviewed on 9/5/19 and indicated a start of care date of 1/26/17. The record contained a plan of care for		100% clinical records were reviewed and verbal orders obtained if needed were sent to Physician to clarify any missing pertinent diagnoses, treatments and measurable goals. Measurable outcomes and goals will be discussed with patient at each skilled nursing encounter and documented. 50% of new admissions and 50% of recert's comprehensive assessments and Plan of Care will be audited for missing pertinent diagnoses, treatments and measurable goals x 2 months by a consultant for evidence of additional insight and education of nursing staff. Clinical director and Administrator will review audits x 2 months to implement any changes Any adverse findings will be reported to QAPI Clinical Director & Administrator will be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	

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	the certification period of 7/15/19-9/12/19 that indicated orders for homemaker (HMK) for 20 hours per moth (5 hours a week), and Attendant (ATTC) Care 20 hours per moth (5 hours a week). The plan of care failed to evidence what tasks these disciplines were to do.			
G 0580 Bldg. 00	Based on record review and interview, the agency failed to ensure the skilled nurse did not provide care to the patient absent of a physician's order for 1 of 4 records reviewed (#1). Findings include: An agency policy dated 2/13/19 titled "Physicians plan of treatment," Policy #2.18 stated "... Physicians' orders are established and documented for the health services [the agency] provides ... verbal orders are to be recorded in the patient's/clients clinical record ...." The clinical record of patient #1 was reviewed on 9/5/19 and indicated a start of care date of 6/9/15. The record contained a plan of care for the certification period of 7/18/19-9/15/19 that indicated a skilled respite nursing frequency of "20 hrs [hours] mo [month] used when wife has to be gone on Thursdays ... patient is vent dependent has respiratory distress and choking episodes when eating .... " The record failed to evidence orders for the nurse to complete care, thus providing care to the patient absent of an order. During a skilled nurse visit completed on 7/18/19 the nurse completed an assessment, got the	G 0580	G-580 SN staff were educated on following a written plan of care established by a physician.SN Staff educated on Respite orders must be included in the plan of care. SN staff were re-counseled that no plan of care can be completed without a physicians order. All patients cited at survey have been corrected 100% of clinical records were reviewed for compliance. Omissions, clarifications and verbal orders will be obtained if needed. Home heath aide staff re-counseled on completing only the tasks on the aide care plan that are within the scope of their practice. 10% of recerts & SOC will be audited Quarterly to evidence physician orders were obtained and Home Health aide staff completing only tasks that are	10/04/2019

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	patient out of bed for 3.5 hours and put the patient back into bed. During a skilled nurse visit completed on 7/25/19 the nurse completed an assessment, got the patient up for lunch and monitored while eating, and took the patient outside. During a skilled nurse visit completed on 8/1/19 the nurse completed an assessment, got the patient up for lunch and monitored while eating, took the patient outside, and the wife requested the nurse measure the wound. During a skilled nurse visit completed on 8/8/19 the nurse completed an assessment, got the patient up for lunch and monitored while eating, took the patient outside, and put the patient back to bed. During a skilled nurse visit completed on 8/15/19 the nurse completed an assessment, got the patient up for lunch and monitored while eating, took the patient outside and right back inside, and put the patient back to bed. During a skilled nurse visit completed on 8/22/19 the nurse completed an assessment, got the patient out of bed and kept up 2.5 hours. During a skilled nurse visit completed on 8/29/19 the nurse visited to see how the patient was because it was the patients birthday. The nurse completed an assessment and the caregiver requested the nurse measure the wound.		within their scope of practice with any adverse findings reported to QAPI Clinical Director will be responsible for monitoring these correct actions to ensure that this deficiency is corrected and will not recur	
G 0716 Bldg. 00		G 0716	G-0716	10/04/2019

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	Based on record review, and interview, the registered nurse (RN) failed to measure wounds weekly for 1 of 2 patients with wounds (#1). Findings include: The clinical record of patient #1 was reviewed on 9/5/19 and indicated a start of care date of 6/9/15. The record contained a plan of care for the certification period of 7/18/19-9/15/19. The agency recertification comprehensive assessment contained wound measurements on 7/15/19 (week 1) Agency skilled nursing visit notes contained measurements on 8/1/19 and 8/29/19 (weeks 3 and 7). The record failed to evidence wound measurements on weeks 2, 4, 5, and 6. During an interview on 9/6/19 at 3:17 PM, the director of nursing stated she taught patient #1's caregiver how to measure and care for the wound back in 2015 and now the caregiver takes care of the wound and will ask the DON to measure only if needed.		Clinical Director has educated/in-serviced nursing staff on policy and procedures for wound documentation to include wound measurements weekly. All records cited at survey have been corrected. 100% clinical records were reviewed and verbal orders obtained if needed were sent to Physician to clarify any missing wound measurements 50% of new admissions and 50% of recert's comprehensive assessments and Plan of Care will be audited for missing wound measurements x 2 months by a consultant for evidence of additional insight and education of nursing staff. Clinical director and Administrator will review audits x 2 months to implement any changes Any adverse findings will be reported to QAPI Clinical Director & Administrator will be responsible for monitoring these corrective actions and to ensure this deficiency is corrected and does not recur	
G 0798 Bldg. 00	Based on record review and interview, the registered nurse (RN) failed to ensure the home	G 0798	G-0798 All HHA were trained/In-serviced	10/04/2019

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	health aide (HHA) documented which shift tasks were completed for 1 of 1 patients receiving multiple shift home health aide services (#1) Findings include: An agency policy dated Nov 2018 titled "Home health aide: document policy," Policy # 2.51 stated "Policy: Home health aides will document care / services provided on the home health aide charting form. Care / services provided should be in accordance with directioin provided in the home hralth aide care plan ...." An agency policy dated July 2017 titled "ATTC[attendant care]," stated "... Essential functions ... Be able to provide covered services according to the client's care plan ... Maintain daily written records but not liited to time sheets ...." The clinical record of patient #1 was reviewed on 9/5/19 and indicated a start of care date of 6/9/15. The record contained a plan of care for the certification period of 7/18/19-9/15/19. The home health aide failed to document which shift each task was completed, but rather just put an 'X' to indicate completed as evidenced by: The agency HHA weekly note with dated 7/14/19-7/20/19 included shifts of 9 AM-11 AM, 1 PM-3PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 'X' on each line. The document failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 7/21/19-7/27/19 included shifts of 9 AM-11 AM, 1 PM-3PM, and 9 PM-11 PM (except Saturday for 3rd shift). . Each task on this document had 1 to 3		about documenting separately when tasks are completed using AM, Noon and PM to designate which shift it was completed. The HHA who completed this documentation incorrectly was counseled in writing to designate shifts accordingly by using Am, Noon or PM with patients whom have multiple shifts. All records cited at survey have been corrected 100% of clinical records were reviewed and verbal orders obtained if needed were sent to the physician for clarification. 10% of all clinical records will be audited quarterly for evidence adhering to this deficiency The Administrator shall be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

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	'X' on each line. The document failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 7/28/19-8/3/19 included shifts of 9 AM-11 M, 1 PM-3PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 'X' on each line. The document failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 8/4/19-8/10/19 included shifts of 9 AM-11 M, 1 PM-3PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 'X' on each line. The document failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 8/11/19-8/17/19 included shifts of 9 AM-11 M, 1 PM-3PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 'X' on each line. The document failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 8/18/19-8/24/19 included shifts of 9 AM-11 M, 1 PM-3PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 'X' on each line. The document failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 8/25/19-8/31/19 included shifts of 9 AM-11 M, 1 PM-3PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 'X' on each line. The document failed to indicate what shift these tasks were completed.			
G 0800				

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Bldg. 00	Based on interview the agency failed to ensure the home health aide (HHA) completed only the tasks on the aide care plan that are within the scope of their practive, and document the tasks completed for 1 of 3 records with aide services (#2) Findings include: An agency policy dated 1/29/17 titled "Home health aide service," Policy # 2.48 stated "... Activities a home helath aide may not perform-the aide will not ... administer medications ... change sterile dressing ... An aide never decides which client care procedures ... she / he will perform. Rather, an aide performs onnly those activities which have been assisned by a nurse ...." The clinical record of patient #2 was reviewed on 9/5/19 and indicated a start of care date of 1/26/17. The record contained a plan of care for the certification period of 7/15/19-9/12/19. The HHA failed to complete tasks only within her scope of practice as evidenced by: During an interview on 9/6/19 at 12:00 PM, employee G, HHA, stated that when the patient fell on 7/29/19 she cleaned up the cut on the patient's leg and bandaged it. She also stated on 9/3/19 she cleaned the cut again, applied triple antibiotic ointment and bandaged it because it looked red.	G 0800	G-0800 Clinical director educated home health aide staff on policy # 2.51 & 2.48 HHA service plan and HHA document policy. HHA are only allowed to complete tasks assigned on the aide care plan that are within their scope of their practice. The HHA sited at survey was counseled to adhere to tag G-0800 ALL SN visits will document aides compliance with assigned duties and completing tasks that are within their scope of practice 25% of clinical records will be audited and adverse findings will be reported to QAPI The Clinical director shall be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	10/04/2019
G 0978 Bldg. 00	Based on record review and interview, the agency	G 0978	G-0978 The Assistant clinical director	10/04/2019

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	failed to ensure a written agreement was in place with other agency's providing care in the home for 1 of 1 shared patients (#) Findings include: An agency policy dated July 2017 titled "Services under contract," Policy # 1.34 stated "Purpose: To assure continuity and quality of services acquired through contract. Policy: A written contract or agreement shall be required for personnel employed on an hourly or on a per visit basis or by arrangement with another home care ...." The agency failed to obtain a written agreement with the other home care agency to delineate tasks between the home heath agencies.		in-serviced nursing staff that a written agreement is require with another agency, an organization, or an individual when that entity or individual furnishes services under arrangement to the HHA'S patients. All records cited at survey have been corrected Heaven Sent Home Health Care, LLC will complete a written agreement by 10-4-19 with all other agencies, organizations, and other entities who furnish services under arrangement to our patients. These written agreements will include all applicable elements noted within this standard. 10% of all clinical records will be audited quarterly for evidence of a written agreement any adverse effects will be reported to the QAPI The Administrator shall be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
N 0000 Bldg. 00	This was a second revisit for the state home health re-licensure survey origionally completed on January 16, 2019.	N 0000		

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	Survey Date: September 5, 6; 2019 Facility Number: 012612 Provider Number: 15K076 Unduplicated Census: 72 Current Census: 44 During this revisit survey, thirteen (13) deficiencies were corrected, six (6) deficiencies were recited, and one (1) new deficiency was cited.			
N 0458 Bldg. 00	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations.			
	Based on record review and interview, the agency failed to ensure that employees had annual performance evaluations for 1 of 3 new employee records reviewed (D).	N 0458	N-0458 The Clinical director in-serviced HR staff that criminal background checks must be applied for not more than three business days after an employee begins providing	10/04/2019

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	Findings include: IC-16-27-2-4 Employees; criminal history stated "... Sec.4. (a) A person who operates a home health agency under IC 16-27-1 or a personal services agency under IC 16-27-4 shall apply, not more than three (3) business days after the date that an employee begins to provide services in a patient ' s temporary or permanent residence, for a copy of the employee ' s criminal history check ...." An agency policy dated 6/28/19 titled "criminal background check," Policy #HB-130 stated "... Policy: The selected candidate in the hiring process must satisfactorily clear a criminal background check ...." An agency document from safe hiring solutions for a national criminal history was ordered on 9/1/19 and completed 9/5/19. The criminal background check failed to be completed by 8/31/19. During the review of employee files on 9/6/19, the list of current employees included employee D, certified nurses assistant, date of hire 8/23/19 and first patient contact date 8/28/19.		services in a patients home. 100% of HR records were reviewed any adverse finds reported to QAPI. All new HR records will be audited x 3 months for evidence that the criminal record was ordered within three business days after employee begins providing services. Then 10% will be audited quarterly and any adverse findings will be reported to QAPI The Administrator shall be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will no recur	
N 0478 Bldg. 00	410 IAC 17-12-2(d) Q A and performance improvement Rule 12 Sec. 2(d) If personnel under contracts are used by the home health agency, there shall be a written contract between those personnel and the home health agency that specifies the following: (1) That patients are accepted for care only by the primary home health agency. (2) The services to be furnished. (3) The necessity to conform to all			

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	applicable home health agency policies including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary home health agency. (6) The procedures for submitting clinical notes, scheduling of visits, and conducting periodic patient evaluation. (7) The procedures for payment for services furnished under the contract. Based on record review, the agency failed to ensure a written agreement was in place with other agency's providing care in the home for 1 of 1 shared patients (#) Findings include: An agency policy dated July 2017 titled "Services under contract," Policy # 1.34 stated "Purpose: To assure continuity and quality of services acquired through contract. Policy: A written contract or agreement shall be required for personnel employed on an hourly or on a per visit basis or by arrangement with another home care ...." The agency failed to obtain a written agreement with the other home care agency to delineate tasks between the home heath agencies.	N 0478	N-0478 The Assistant clinical director in-serviced nursing staff that a written agreement is require with another agency, an organization, or an individual when that entity or individual furnishes services under arrangement to the HHA'S patients. All records cited at survey have been corrected Heaven Sent Home Health Care, LLC will complete a written agreement by 10-4-19 with all other agencies, organizations, and other entities who furnish services under arrangement to our patients. These written agreements will include all applicable elements noted within this standard. 10% of all clinical records will be audited quarterly for evidence of a written agreement any adverse effects will be reported to the QAPI	10/04/2019

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			The Administrator shall be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on record review and interview, the agency failed to ensure the skilled nurse did not provide care to the patient absent of a physician's order for 1 of 4 records reviewed (#1) and failed to ensure the home health aide (HHA) completed only the tasks on the aide care plan that are within the scope of their practive, and document the tasks completed for 1 of 3 records with aide services (#2). Findings include: 1. An agency policy dated 2/13/19 titled "Physicians plan of treatment," Policy #2.18 stated "... Physicians' orders are established and documented for the health services [the agency] provides ... verbal orders are to be recorded in the patient's/clients clinical record ...." 2. An agency policy dated 1/29/17 titled "Home health aide service," Policy # 2.48 stated "... Activities a home helath aide may not perform-the aide will not ... administer medications ... change sterile dressing ... An aide never decides which client care procedures ... she / he will perform. Rather, an aide performs onnly those activities	N 0522	N-522 SN staff were educated on following a written plan of care established by a physician.SN Staff educated on Respite orders must be included in the plan of care. SN staff were re-counseled that no plan of care can be completed without a physicians order. All patients cited at survey have been corrected 100% of clinical records were reviewed for compliance. Omissions, clarifications and verbal orders will be obtained if needed. Home heath aide staff re-counseled on completing only the tasks on the aide care plan that are within the scope of their practice. 10% of recerts & SOC will be audited Quarterly to evidence	10/04/2019

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	which have been assisned by a nurse ...." 3. The clinical record of patient #1 was reviewed on 9/5/19 and indicated a start of care date of 6/9/15. The record contained a plan of care for the certification period of 7/18/19-9/15/19 that indicated a skilled respite nursing frequency of "20 hrs [hours] mo [month] used when wife has to be gone on Thursdays ... patient is vent dependent has respiratory distress and choking episodes when eating .... " The record failed to evidence orders for the nurse to complete care, thus providing care to the patient absent of an order. During a skilled nurse visit completed on 7/18/19 the nurse completed an assessment, got the patient out of bed for 3.5 hours and put the patient back into bed. During a skilled nurse visit completed on 7/25/19 the nurse completed an assessment, got the patient up for lunch and monitored while eating, and took the patient outside. During a skilled nurse visit completed on 8/1/19 the nurse completed an assessment, got the patient up for lunch and monitored while eating, took the patient outside, and the wife requested the nurse measure the wound. During a skilled nurse visit completed on 8/8/19 the nurse completed an assessment, got the patient up for lunch and monitored while eating, took the patient outside, and put the patient back to bed. During a skilled nurse visit completed on 8/15/19 the nurse completed an assessment, got the patient up for lunch and monitored while eating,		physician orders were obtained and Home Health aide staff completing only tasks that are within their scope of practice with any adverse findings reported to QAPI Clinical Director will be responsible for monitoring these correct actions to ensure that this deficiency is corrected and will not recur	

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	took the patient outside and right back inside, and put the patient back to bed. During a skilled nurse visit completed on 8/22/19 the nurse completed an assessment, got the patient out of bed and kept up 2.5 hours. During a skilled nurse visit completed on 8/29/19 the nurse visited to see how the patient was because it was the patients birthday. The nurse completed an assessment and the caregiver requested the nurse measure the wound. 4. The clinical record of patient #2 was reviewed on 9/5/19 and indicated a start of care date of 1/26/17. The record contained a plan of care for the certification period of 7/15/19-9/12/19. The HHA failed to complete tasks only within her scope of practice as evidenced by: During an interview on 9/6/19 at 12:00 PM, employee G, HHA, stated that when the patient fell on 7/29/19 she cleaned up the cut on the patient's leg and bandaged it. She also stated on 9/3/19 she cleaned the cut again, applied triple antibiotic ointment and bandaged it because it looked red.			
N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment			

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	required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.			
	Based on record review and interview, the agency failed to ensure the plan of care (POC) included all pertinent treatments, orders, and goals in 2 of 4 records reviewed. (#1, 2). Findings include: 1. An agency policy dated 2/13/19 titled "Physicians plan of treatment," Policy #2.18 stated "... A physician's plan of treatment must be signed by the physician and in the chart within 30 days after admission to [agency] and must include: ... The type and frequency of services needed ... specific orders ... necessary medical supplies and equipment ...." 2. An agency policy dated 6/28/19 titled "Clinical management and assignments," Policy # 2.10 stated "... Essential unctions ... Develops and / or follows an individualized plan of care ...." 3. The clinical record of patient #1 was reviewed on 9/5/19 and indicated a start of care date of 6/9/15. The record contained a plan of care for the	N 0524	N-0524 Clinical Director has educated/in-serviced nursing staff on N-0524 including all pertinent diagnoses, treatments and measurable outcomes assessments for accurate documentation. All records cited at survey have been corrected. 100% clinical records were reviewed and verbal orders obtained if needed were sent to Physician to clarify any missing pertinent diagnoses, treatments and measurable goals. Measurable outcomes and goals will be discussed with patient at each skilled nursing encounter and documented. 50% of new admissions and 50% of recert's comprehensive assessments and Plan of Care will be audited for missing pertinent	10/04/2019

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	certification period of 7/18/19-9/15/19 that indicated a skilled respite nursing frequency of "20 hrs [hours] mo [month] used when wife has to be gone on Thursdays ... patient is vent dependent has respiratory distress and choking episodes when eating .... " The plan of care failed to evidence the needs of the patient with the tasks (orders) the nurse was to complete while in the home, the type of ventilator, ventilator settings, wound care orders, a frequency that reflects the needs of the patient, and goals for dyspnea and the wound. The recertification comprehensive assessment completed on 7/15/19 was blank under the respiratory status. Under DME [durable medical equipment] and supplies it stated "vent O2[oxygen] supplies." The integumentary status stated the patient had a pressure ulcer on the sacrum and the wife completed a wet to dry dressing daily. 4. The clinical record of patient #2 was reviewed on 9/5/19 and indicated a start of care date of 1/26/17. The record contained a plan of care for the certification period of 7/15/19-9/12/19 that indicated orders for homemaker (HMK) for 20 hours per moth (5 hours a week), and Attendant (ATTC) Care 20 hours per moth (5 hours a week). The plan of care failed to evidence what tasks these disciplines were to do.		diagnoses, treatments and measurable goals x 2 months by a consultant for evidence of additional insight and education of nursing staff. Clinical director and Administrator will review audits x 2 months to implement any changes Any adverse findings will be reported to QAPI Clinical Director & Administrator will be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	
N 0533 Bldg. 00	410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a			

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	skilled service. (b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan.			
	Based on record review and interview, the registered nurse (RN) failed to ensure the home health aide (HHA) documented which shift tasks were completed for 1 of 1 patients receiving multiple shift home health aide services (#1) Findings include: An agency policy dated Nov 2018 titled "Home health aide: document policy," Policy # 2.51 stated "Policy: Home health aides will document care / services provided on the home health aide charting form. Care / services provided should be in accordance with directioin provided in the home hralth aide care plan ...." An agency policy dated July 2017 titled "ATTC[attendant care]," stated "... Essential functions ... Be able to provide covered services according to the client's care plan ... Maintain daily written records but not liited to time sheets ...."	N 0533	N-0533 All HHA were retrained/In-serviced about documenting separately when tasks are completed using AM, Noon and PM to designate which shift it was completed. The HHA who completed this documentation incorrectly was counseled in writing to designate shifts accordingly by using Am, Noon or PM with patients whom have multiple shifts. All records cited at survey have been corrected 100% of clinical records were reviewed and verbal orders obtained if needed were sent to the physician for clarification. 10% of all clinical records will be audited quarterly for evidence adhering to this deficiency	10/04/2019

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	The clinical record of patient #1 was reviewed on 9/5/19 and indicated a start of care date of 6/9/15. The record contained a plan of care for the certification period of 7/18/19-9/15/19. The home health aide failed to document which shift each task was completed, but rather just put an 'X' to indicate completed as evidenced by: The agency HHA weekly note with dated 7/14/19-7/20/19 included shifts of 9 AM-11 AM, 1 PM-3PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 'X' on each line. The document failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 7/21/19-7/27/19 included shifts of 9 AM-11 AM, 1 PM-3PM, and 9 PM-11 PM (except Saturday for 3rd shift). . Each task on this document had 1 to 3 'X' on each line. The document failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 7/28/19-8/3/19 included shifts of 9 AM-11 M, 1 PM-3PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 'X' on each line. The document failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 8/4/19-8/10/19 included shifts of 9 AM-11 M, 1 PM-3PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 'X' on each line. The document failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 8/11/19-8/17/19 included shifts of 9 AM-11 M, 1 PM-3PM, and 9 PM-11 PM (except Saturday for		The Administrator shall be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

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	3rd shift). Each task on this document had 1 to 3 'X' on each line. The document failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 8/18/19-8/24/19 included shifts of 9 AM-11 M, 1 PM-3PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 'X' on each line. The document failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 8/25/19-8/31/19 included shifts of 9 AM-11 M, 1 PM-3PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 'X' on each line. The document failed to indicate what shift these tasks were completed.			
N 0541 Bldg. 00	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review, and interview, the registered nurse (RN) failed to ensure that the comprehensive assessment contained all information regarding the patient's current health status for 1 of 4 records (#1). Findings include: An agency policy dated 1/29/17 titled "Guidelines for assessment," Policy # 2.05 stated "... Initial comprehensive assessment: 1. The initial assessment form is utilized by the RN for the	N 0541	N-0541 Assistant clinical director retrained/In-serviced on Completing a comprehensive assessment The RN whom completed this assessment which failed to contain all of the patients current health status as sited in finding was counseled in writing and retrained to include all information regarding the patients current	10/04/2019

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	initial evaluation and / or assessment in order to: ... Determine the need for home care and services and the type of care and services to be provided ... will include ... supplies and equipment required ... pertinent physical findings ... equipment needs ... Reassessment: ... The reassessment process is ongoing throughout the client's contact with [agency]. Each client is reassessed to determine the client's response to care or services. Reassessment occurs: ... Every 60 days when the client is receiving services." An agency policy dated January 2018 titled "RN clinical Manager," Policy # HC-105 stated "... Essential functions ... Performs comprehensive assessments of client status, including physical ... parameters ...." The clinical record of patient #1 was reviewed on 9/5/19 and indicated a start of care date of 6/9/15. The record contained a plan of care for the certification period of 7/18/19-9/15/19 that indicated a skilled respite nursing frequency of "20 hrs [hours] mo [month] used when wife has to be gone on Thursdays ... patient is vent dependent has respiratory distress and choking episodes when eating .... " The record failed to evidence the current respiratory status as evidenced by: The recertification comprehensive assessment completed on 7/15/19 was blank under the respiratory status. It failed to identify the patient's breath sounds, cough, if was a smoker, sputum, if had orthopnea, hemoptysis, or cyanosis, or tracheotomy information including size. Under DME [durable medical equipment] and supplies it stated "vent O2[oxygen] supplies." The comprehensive assessment failed to evidence the needs of the patient and tasks the		health status. All patients cited at survey have been corrected 10% of all clinical charts will be audited quarterly to adhere to this deficiency and any adverse effect will be reported to the QAPI Clinical Manager/Administrator will be responsible for monitoring these corrective actions and to ensure this deficiency is corrected and will not recur	

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	nurse was to complete while in the home, the type of ventilator, ventilator settings, or choking episodes. During an interview on 9/5/19 at 11:10 AM, the director of nursing stated she was leaving the office to see a patient (Patient #1). She stated the patient is "a vent patient," and the last person alive that came off the iron lung. She also stated "he is respite only."			
N 0544 Bldg. 00	410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on record review, and interview, the registered nurse (RN) failed to measure wounds weekly for 1 of 2 patients with wounds (#1). Findings include: The clinical record of patient #1 was reviewed on 9/5/19 and indicated a start of care date of 6/9/15. The record contained a plan of care for the certification period of 7/18/19-9/15/19. The agency recertification comprehensive assessment contained wound measurements on 7/15/19 (week 1) Agency skilled nursing visit notes contained measurements on 8/1/19 and 8/29/19 (weeks 3 and 7). The record failed to evidence wound measurements on weeks 2, 4, 5, and 6.	N 0544	N-544 Clinical Director has educated/in-serviced nursing staff on policy and procedures for wound documentation to include wound measurements weekly. All records cited at survey have been corrected. 100% clinical records were reviewed and verbal orders obtained if needed were sent to Physician to clarify any missing wound measurements 50% of new admissions and 50% of recert's comprehensive assessments and Plan of Care will be audited for missing wound measurements x 2 months by a consultant for evidence of	10/04/2019

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HEAVEN SENT HOME HEALTH CARE LLC	10484 N STATE ROAD 13 ELWOOD, IN 46036

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	During an interview on 9/6/19 at 3:17 PM, the director of nursing stated she taught patient #1's caregiver how to measure and care for the wound back in 2015 and now the caregiver takes care of the wound and will ask the DON to measure only if needed.		additional insight and education of nursing staff. Clinical director and Administrator will review audits x 2 months to implement any changes Any adverse findings will be reported to QAPI Clinical Director & Administrator will be responsible for monitoring these corrective actions and to ensure this deficiency is corrected and does not recur	