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

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K076		A. BUILDING <u>00</u> COM			(X3) DATE COMPI 09/06	LETED	
	PROVIDER OR SUPPLIER SENT HOME HEA			10484 N	ADDRESS, CITY, STATE, ZIP COD N STATE ROAD 13 DD, IN 46036		
(X4) ID PREFIX TAG G 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
Bldg. 00	the federal home he origionally completed Survey Date: Septed Facility Number: 0 Provider Number: 1 Unduplicated Cens Current Census: 44 Sample: Record Review With Record Review With Total Home Visits: Total Records Review During this survey, participation, twenth were found corrected deficiencies were recorded from provided training and conformation of 2 years to January 16, 2021 compliance with the CFR 484.50 Patient Assessment of Patic coordination, quality	th Home Visits: 1 thout Home Visits: 3 1 ewed: 4 two conditions of y standard level deficiencies ed, seven standard level	G 0	0000			

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

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 15K076 B. WING 09/06/2019 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10484 N STATE ROAD 13 HEAVEN SENT HOME HEALTH CARE LLC ELWOOD, IN 46036 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE G 0528 Bldg. 00 G 0528 G-0528 10/04/2019 Based on record review, and interview, the registered nurse (RN) failed to ensure that the Assistant clinical director comprehensive assessment contained all retrained/In-serviced on information regarding the patient's current health Completing a comprehensive status for 1 of 4 records (#1). assessment The RN whom completed this Findings include: assessment which failed to contain all of the patients current An agency policy dated 1/29/17 titled "Guidelines health status as sited in finding for assessment," Policy # 2.05 stated "... Initial was counseled in writing and comprehensive assessment: 1. The initial retrained to include all information assessment form is utilized by the RN for the regarding the patients current initial evaluation and / or assessment in order to: health status. ... Determine the need for home care and services All patients cited at survey have and the type of care and services to be provided been corrected ... will include ... supplies and equipment required ... pertinent physical findings ... equipment needs 10% of all clinical charts will be ... Reassessment: ... The reassessment process is audited quarterly to adhere to this ongoing throughout the client's contact with deficiency and any adverse effect [agency]. Each client is reassessed to determine will be reported to the QAPI the client's response to care or services. Reassessment occurs: ... Every 60 days when the Clinical Manager/Administrator will client is receiving services." be responsible for monitoring these corrective actions and to An agency policy dated January 2018 titled "RN ensure this deficiency is corrected clinical Manager," Policy # HC-105 stated "... and will not recur 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

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"20 hrs [hours] mo [month] used when wife has to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15K076	B. WI	NG		09/06/	2019
	ROVIDER OR SUPPLIER			10484 N	ADDRESS, CITY, STATE, ZIP COD N STATE ROAD 13 DD, IN 46036		
(X4) ID	SUMMARYS	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	IE.	DATE
	episodes when eatin evidence the current evidenced by:	ratory distress and choking ag " The record failed to t respiratory status as 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.						
	director of nursing s office to see a patien patient is "a vent pa	on 9/5/19 at 11:10 AM, the stated she was leaving the nt (Patient #1). She stated the tient," and the last person the iron lung. She also stated					
G 0574							
Bldg. 00			G 05	574	G-0574		10/04/2019
	failed to ensure the pertinent treatments records reviewed. (#Findings include: 1. An agency policy	y dated 2/13/19 titled			Clinical Director has educated/in-serviced nursing s on G574 including all pertinent diagnoses, treatments and measurable outcomes assessments for accurate documentation. All records cited	ed	
	"Physicians plan of	treatment," Policy #2.18			at survey have been corrected		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15K076 B. WING 09/06/2019 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10484 N STATE ROAD 13 HEAVEN SENT HOME HEALTH CARE LLC ELWOOD, IN 46036 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE stated "... A physician's plan of treatment must be 100% clinical records were signed by the physician and in the chart within 30 reviewed and verbal orders days after admission to [agency] and must obtained if needed were sent to include: ... The type and frequency of services Physician to clarify any missing needed ... specific orders ... necessary medical pertinent diagnoses, treatments supplies and equipment" and measurable goals. Measurable outcomes and goals 2. An agency policy dated 6/28/19 titled "Clinical will be discussed with patient at management and assignments," Policy # 2.10 each skilled nursing encounter stated "... Essential unctions ... Develops and / or and documented. follows an individualized plan of care" 50% of new admissions and 50% 3. The clinical record of patient #1 was reviewed of recert's comprehensive on 9/5/19 and indicated a start of care date of assessments and Plan of Care will 6/9/15. The record contained a plan of care for the be audited for missing pertinent certification period of 7/18/19-9/15/19 that diagnoses, treatments and indicated a skilled respite nursing frequency of measurable goals x 2 months by a "20 hrs [hours] mo [month] used when wife has to consultant for evidence of be gone on Thursdays ... patient is vent additional insight and education of dependent has respiratory distress and choking nursing staff. Clinical director and episodes when eating " The plan of care failed Administrator will review audits x 2 to evidence the needs of the patient with the tasks months to implement any changes (orders) the nurse was to complete while in the Any adverse findings will be home, the type of ventilator, ventilator settings, reported to QAPI wound care orders, a frequency that reflects the needs of the patient, and goals for dyspnea and Clinical Director & Administrator the wound. will be responsible for monitoring these corrective actions and to The recertification comprehensive assessment ensure this deficiency does not completed on 7/15/19 was blank under the recur 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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K076		(X2) MULTIPLE CO A. BUILDING B. WING	X3) DATE SURVEY COMPLETED 09/06/2019		
	PROVIDER OR SUPPLIER		10484	ADDRESS, CITY, STATE, ZIP COD N STATE ROAD 13 OD, IN 46036	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	
TAG	the certification per indicated orders for hours per moth (5 h (ATTC) Care 20 ho	iod of 7/15/19-9/12/19 that homemaker (HMK) for 20 ours a week), and Attendant ours per moth (5 hours a week). led to evidence what tasks ere to do.	TAG	DEFICIENCY)	DATE
G 0580					
Bldg. 00	failed to ensure the care to the patient a for 1 of 4 records reference in the patient and for 1 of 4 records reference in the patient," An agency policy deplan of treatment," Physicians' orders and documented for the provides verbal of patient's/clients climing the provides verbal of patient's/clients climing the provides and indicated. The record contained certification period indicated a skilled recording the provider of the providing care order.	ated 2/13/19 titled "Physicians Policy #2.18 stated " are established and health services [the agency] orders are to be recorded in the nical record" of patient #1 was reviewed on a start of care date of 6/9/15. The date of a plan of care for the of 7/18/19-9/15/19 that respite nursing frequency of [month] used when wife has to the nurse to complete care, to the patient absent of an	G 0580	G-580 SN staff were educated on following a written plan of care established by a physician.SN Staff educated on Respite order must be included in the plan of care. SN staff were re-counseled that 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 on the tasks on the aide care plan that are within the scope of the practice. 10% of recerts & SOC will be audited Quarterly to evidence physician orders were obtained and Home Health aide staff	t no
	_	rse visit completed on 7/18/19 If an assessment, got the		and Home Health aide staff completing only tasks that are	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K076		A. BU	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING 00 B. WING			survey eted 2019	
	ROVIDER OR SUPPLIER SENT HOME HEA			10484 N	NDDRESS, CITY, STATE, ZIP COD N STATE ROAD 13 DD, 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 APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	patient out of bed for 3.5 hours and put the patient back into bed.				within their scope of practice w any adverse findings reported QAPI		
	the nurse completed patient up for lunch and took the patient. During a skilled nurthe nurse completed patient up for lunch took the patient out the nurse measure to the nurse completed patient up for lunch took the patient out to bed. During a skilled nurthe nurse completed patient up for lunch took the patient out to bed. During a skilled nurthe nurse completed patient up for lunch took the patient out put the patient out put the patient out put the patient back.	rse visit completed on 8/1/19 If an assessment, got the and monitored while eating, side, and the wife requested the wound. rse visit completed on 8/8/19 If an assessment, got the and monitored while eating, side, and put the patient back rse visit completed on 8/15/19 If an assessment, got the and monitored while eating, side and right back inside, and			Clinical Director will be responsible for monitoring thes correct actions to ensure that the deficiency is corrected and will recur	his	
	During a skilled nur the nurse visited to because it was the p completed an assess	rse visit completed on 8/29/19 see how the patient was patients birthday. The nurse sment and the caregiver measure the wound.					
G 0716							
Bldg. 00			G 0	716	G-0716		10/04/2019

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NAME OF P	PROVIDER OR SUPPLIER	<u> </u>		ADDRESS, CITY, STATE, ZIP COD N STATE ROAD 13	
HEAVEN	SENT HOME HEA	LTH CARE LLC		OD, IN 46036	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
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		view, and interview, the			
	-	N) failed to measure wounds		Clinical Director has	
	weekly for 1 of 2 patients with wounds (#1).			educated/in-serviced nursing	staff
	E' 1' ' 1 1			on policy and procedures for	
	Findings include:			wound documentation to inclu	
	The clinical record	of patient #1 was reviewed on		wound measurements weekly records cited at survey have to	
		d a start of care date of 6/9/15.		corrected.	
		ed a plan of care for the		100% clinical records were	
	certification period	of 7/18/19-9/15/19.		reviewed and verbal orders	
				obtained if needed were sent	to
	The agency recertification comprehensive assessment contained wound measurements on 7/15/10 (1 1)		ng		
			wound measurements		
	//15/19 (week 1)	7/15/19 (week 1)		50% of new admissions and 5	:00/
	Agency skilled nurs	sing visit notes contained		of recert's comprehensive	0070
		1/1/19 and 8/29/19 (weeks 3 and		assessments and Plan of Car	e will
		ed to evidence wound		be audited for missing wound	
	measurements on w	reeks 2, 4, 5, and 6.		measurements x 2 months by	а
				consultant for evidence of	
	-	on 9/6/19 at 3:17 PM, the		additional insight and education	
		stated she taught patient #1's		nursing staff. Clinical director	
	-	easure and care for the wound ow the caregiver takes care of		Administrator will review audit months to implement any cha	
		ask the DON to measure only		Any adverse findings will be	nges
	if needed.	and the Bore to incusting only		reported to QAPI	
				Clinical Director & Administra	
				will be responsible for monitor	~
				these corrective actions and t	
				ensure this deficiency is corre and does not recur	cted
				and does not recur	
G 0798					
Bldg. 00					
	Dogad on magard	view and interview the	G 0798	G-0798	10/04/2019
		view and interview, the		All HHA were trained/In-service	red

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPLETE	D	
		15K076	B. W	ING		09/06/201	9	
				CTDEET A	ADDRESS OF WATE TO COD			
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD			
	OENT HOME HEA	LTILOADELLO			N STATE ROAD 13			
HEAVEN	SENT HOME HEA	ALTH CARE LLC		ELWOC	DD, IN 46036			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	_ co	MPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE	
	health aide (HHA)	documented which shift tasks			about documenting separately			
	· · ·	1 of 1 patients receiving			when tasks are completed using			
		health aide services (#1)			AM, Noon and PM to designat	-		
		()			which shift it was completed.	Ĭ		
	Findings include:				The HHA who completed this			
	i mamga meraac.				documentation incorrectly was			
	An agency policy d	ated Nov 2018 titled "Home			counseled in writing to designate			
		ent policy," Policy # 2.51 stated			shifts accordingly by using Am			
		Ith aides will document care /			Noon or PM with patients who			
	I -	n the home health aide			have multiple shifts.	"		
	_	e / services provided should be			All records cited at survey hav	_		
	_	direction provided in the			been corrected	-		
	home hralth aide ca	-						
	nome mann aide ca	ne pian			100% of clinical records were			
	A	-4-4 I-1- 2017 4:41-4			reviewed and verbal orders			
		ated July 2017 titled			obtained if needed were sent t	°		
	_	are]," stated " Essential			the physician for clarification.			
		e to provide covered services						
		ent's care plan Maintain			10% of all clinical records will	oe		
	1	ls but not liited to time sheets			audited quarterly for evidence			
	"				adhering to this deficiency			
		0						
		of patient #1 was reviewed on			The Administrator shall be			
		d a start of care date of 6/9/15.			responsible for monitoring the			
		ed a plan of care for the			corrective actions to ensure th			
		of 7/18/19-9/15/19. The home			this deficiency is corrected and	i		
		document which shift each			will not recur			
	_	, but rather just put an 'X' to						
	indicate completed	as evidenced by:						
	1	veekly note with dated						
		cluded shifts of 9 AM-11 AM, 1						
	· ·	I-11 PM (except Saturday for						
	· · · · · · · · · · · · · · · · · · ·	k on this document had 1 to 3						
		ne document failed to indicate						
	what shift these tasl	ks were completed.						
		veekly note with dated						
	7/21/19-7/27/19 inc	cluded shifts of 9 AM-11 AM, 1						
	PM-3PM, and 9 PM	M-11 PM (except Saturday for						
	3rd shift) Each to	ask on this document had 1 to 3						

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AND PLAN OF CORRECTION IN WING NAME OF PROVIDER OR SUPPLIER HEAVEN SENT HOME HEALTH CARE LLC (X4) ID SIMMARY STATIMENT OF DIFFCENCIE PREFEX (EACH DEFICIENCY MUST BE PRECEDED BY PLLL RAGE TO REAL BLOCK SUPPLIER (X5) ID SUMMARY STATIMENT OF DIFFCENCIE PREFEX (EACH DEFICIENCY MUST BE PRECEDED BY PLLL RAGE REQUIREMENT OF COMPLETION TAG N'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-3-PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 N'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-3-PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 N'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-3-PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 N'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-3-PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 N'on each line. The document failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 8/25/19-8/31/9 included shifts of 9 AM-11 M, 1 PM-3-PM, and 9 PM-11 PM (except Saturday for 3rd shift). Each task on this document had 1 to 3 N'on each line. The document failed to indicate what shift these tasks were completed.	STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER HEAVEN SENT HOME HEALTH CARE LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE REFIX GEACH DEFICIENCY MUST BE PRECEDED BY PILL AGO SUMMARY STATEMENT OF DEFICIENCIE RECLIATORY OR LISC IDENTIFYING BY PROFENDATION X' on each line. The document fuiled 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 fuiled 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 fuiled 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 0 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 0 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 0 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.	AND PLAN	OF CORRECTION						
HEAVEN SENT HOME HEALTH CARE LLC GAULD SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG To each lim. The document failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 84/19-87/1019 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 failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 84/19-87/1019 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 failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 81/11/19-81/719 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 failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 81/11/19-81/719 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 failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 81/819-82/419 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 thad 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 81/819-82/419 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 thad 1 to 3 'X' on each line. The document failed to indicate what shift these tasks to n this document thad 1 to 3 'X' on each line. The document failed to indicate what shift these tasks were completed.			15K076	B. WIN	NG		09/06/	2019
HEAVEN SENT HOME HEALTH CARE LLC (CA) ID SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG X' on each line. The document failed to indicate what shift these tasks were completed. The agency HHA weekly note with dated 8x119-8x109 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 8x119-8x109 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 8x119-8x1019 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 8x18/19-8x24/19 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 8x18/19-8x24/19 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 8x25/19-8x31/19 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.	NAME OF P	ROVIDER OR SUPPLIER						
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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.		'X' on each line. Th	ne document failed to indicate					
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.		what shift these task	ks were completed.					
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.		771 11114	11					
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.			-					
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.			-					
'X' on each line. The document failed to indicate what shift these tasks were completed.								
what shift these tasks were completed.		· ·						
G 0800								
	G 0800							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

60LY13 Facility ID: 012612

If continuation sheet Page 9 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPL	ETED	
		15K076	B. WI	NG _		09/06/	2019
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				N STATE ROAD 13		
HEAVEN	SENT HOME HEA	LTH CARE LLC			DD, IN 46036		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i.C	DATE
Bldg. 00							
			G 0	800	G-0800		10/04/2019
	Based on interview	the agency failed to ensure					
	the home health aid	e (HHA) completed only the			Clinical director educated hom	ie	
	tasks on the aide car	re plan that are within the			health aide staff on policy # 2.	51 &	
	scope of their practi	ve, and document the tasks			2.48 HHA service plan and HH	łΑ	
	completed for 1 of 3	3 records with aide services			document policy. HHA are only	y	
	(#2)				allowed to complete tasks		
					assigned on the aide care plar	ı	
	Findings include:				that are within their scope of the	neir	
					practice.		
	An agency policy dated 1/29/17 titled "Home				The HHA sited at survey was		
	health aide service," Policy # 2.48 stated "				counseled to adhere to tag G-	0800	
	Activities a home helath aide may not perform-the						
	aide will not adm	inister medications change			ALL SN visits will document ai	des	
	sterile dressing A	n aide never decides which			compliance with assigned duti	es	
	client care procedur	es she / he will perform.	and completing tasks that are				
		orms onnly those activities			within their scope of practice		
	which have been as	sisned by a nurse"					
					25% of clinical records will be		
		of patient #2 was reviewed on			audited and adverse findings v	vill	
		d a start of care date of 1/26/17.			be reported to QAPI		
		ed a plan of care for the					
		of 7/15/19-9/12/19. The HHA			The Clinical director shall be		
	•	asks only within her scope of			responsible for monitoring thes		
	practice as evidence	ed by:			corrective actions and to ensu	re	
					this deficiency does not recur		
	-	on 9/6/19 at 12:00 PM,					
		stated that when the patient					
		cleaned up the cut on the					
		ndaged it. She also stated on					
		he cut again, applied triple					
		and bandaged it because it					
	looked red.						
C 0070							
G 0978							
Bldg. 00							
Diag. 00				070	G-0978		10/04/2010
	Rosed on record rev	view and interview the agency	G 09	9/8			10/04/2019
	Daseu on record rev	riew and interview, the agency			The Assistant clinical director		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

60LY13 Facility ID: 012612

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PRINTED: 10/23/2019 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K076		A. BUILDING B. WING	00	COMPLETED 09/06/2019
	ROVIDER OR SUPPLIER SENT HOME HEA	TH CARE LLC	10484 1	ADDRESS, CITY, STATE, ZIP COD N STATE ROAD 13 DD, IN 46036	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	DED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		(X5) COMPLETION DATE
	failed to ensure a with other agency's 1 of 1 shared patient. Findings include: An agency policy da under contract," Pol assure continuity an through contract. Pol agreement shall be remployed on an houby arrangement with.	itten agreement was in place providing care in the home for s (#) Inted July 2017 titled "Services licy # 1.34 stated "Purpose: To did quality of services acquired licy: A written contract or equired for personnel rily or on a per visit basis or another home care"		in-serviced nursing staff that a written agreement is require w another agency, an organizatio or an individual when that entiindividual furnishes services u arrangement to the HHA'S patients. All records cited at survey have been corrected Heaven Sent Home Health Calluc will complete a written agreement by 10-4-19 with all other agencies, organizations, other entities who furnish servunder arrangement to our pation these written agreements will include all applicable elements noted within this standard. 10% of all clinical records will audited quarterly for evidence written agreement any adverse effects will be reported to the QAPI The Administrator shall be responsible for monitoring the corrective actions to ensure the this deficiency is corrected and will not recur.	rith on, ty or nder e are, and ices ents. be of a e se at
N 0000 Bldg. 00		evisit for the state home	N 0000		
	health re-licensure s on January 16, 2019	urvey origionally completed .			

State Form Event ID: 60LY13 Facility ID: 012612 If continuation sheet Page 11 of 25

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K076	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/06/2019	
	ROVIDER OR SUPPLIER		10484 I	ADDRESS, CITY, STATE, ZIP COD N STATE ROAD 13 DD, IN 46036		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	Survey Date: Septe Facility Number: 0 Provider Number: 1	12612				
	Unduplicated Cens Current Census: 44	us: 72				
		urvey, thirteen (13) prected, six (6) deficiencies ne (1) new deficiency was				
N 0458	410 IAC 17-12-1(f Home health ager					
Bldg. 00	administration/mai Rule 12 Sec. 1(f) employees shall b policies. All emploi Indiana shall be so certification, or rece perform the respect records of employ health services shall include docu the job, including to (1) Receipt of job (2) Qualifications (3) A copy of limi pursuant to IC 16- (4) A copy of curtor registration.	Personnel practices for e supported by written byees caring for patients in ubject to Indiana licensure, gistration required to ctive service. Personnel ees who deliver home all be kept current and mentation of orientation to the following: description. ted criminal history	N 0459	N_0458	10/04/2010	
	failed to ensure that	riew and interview, the agency employees had annual tions for 1 of 3 new employee D).	N 0458	N-0458 The Clinical director in-service HR staff that criminal backgro checks must be applied for no more than three business day after an employee begins pro-	und ot s	

State Form Event ID: 60LY13 Facility ID: 012612 If continuation sheet Page 12 of 25

PRINTED: 10/23/2019 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15K076		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE COMPL 09/06/	ETED	
	PROVIDER OR SUPPLIER		10484	ADDRESS, CITY, STATE, ZIP COD N STATE ROAD 13 OD, IN 46036		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
	Sec. 4. (a) A person agency under IC 16 agency under IC 16 than three (3) busin the date that an empservices in a patient residence, for a cophistory check" An agency policy d background check," Policy: The selected process must satisfat background check. An agency document for a national crimin 9/1/19 and complete background check f8/31/19. During the review of list of current employed.	ployee begins to provide I's temporary or permanent by of the employee 's criminal ated 6/28/19 titled "criminal Policy #HB-130 stated " I candidate in the hiring actorily clear a criminal" In the from safe hiring solutions hal history was ordered on ed 9/5/19. The criminal atiled to be completed by of employee files on 9/6/19, the eyees included employee D, stant, date of hire 8/23/19 and		services in a patients home 100% of HR records were reany adverse finds reported QAPI. All new HR records will be a x 3 months for evidence that criminal record was ordered three business days after employee begins providing services. Then 10% will be quarterly and any adverse f will be reported to QAPI The Administrator shall be responsible for monitoring the corrective actions to ensure this deficiency is corrected a will no recur	eviewed to audited at the I within audited indings	
N 0478	410 IAC 17-12-2(d Q A and performa	•				
Bldg. 00	Rule 12 Sec. 2(d) contracts are used agency, there sha between those pe health agency tha (1) That patients by the primary hor (2) The services	If personnel under If by the home health If be a written contract resonnel and the home It specifies the following: are accepted for care only me health agency.				

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PRINTED: 10/23/2019 FORM APPROVED OMB NO. 0938-039

	EMENT OF DEFICIENCIES PLAN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K076	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/06/2019
	E OF PROVIDER OR SUPPLI VEN SENT HOME HE		10484	ADDRESS, CITY, STATE, ZIP COD N STATE ROAD 13 OD, IN 46036	
(X4) I PREF TA	IX (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	including person (4) The respondeveloping plans (5) The manne controlled, coord primary home he (6) The proced notes, schedulin periodic patient (7) The proced furnished under Based on record rensure a written a agency's providin shared patients (# Findings include: An agency policy under contract," Passure continuity through contract agreement shall be employed on an head of the process of	r in which services will be linated, and evaluated by the ealth agency. ures for submitting clinical g of visits, and conducting evaluation. ures for payment for services the contract. eview, the agency failed to greement was in place with other g care in the home for 1 of 1	N 0478	N-0478 The Assistant clinical director in-serviced nursing staff that a written agreement is require wi another agency, an organizatio or an individual when that entit individual furnishes services ur arrangement to the HHA'S patients. All records cited at survey have been corrected Heaven Sent Home Health Ca LLC will complete a written agreement by 10-4-19 with all other agencies, organizations, other entities who furnish servi under arrangement to our patie These written agreements will include all applicable elements noted within this standard. 10% of all clinical records will be audited quarterly for evidence written agreement any adverse effects will be reported to the QAPI	ith on, cy or nder e re, and deces ents.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K076		(X2) MULTIPLE (A. BUILDING B. WING	OO CONSTRUCTION Q	COMPLETED 09/06/2019	
	PROVIDER OR SUPPLIER		10484	r ADDRESS, CITY, STATE, ZIP COD N STATE ROAD 13 OOD, 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
				The Administrator shall be responsible for monitoring these corrective actions to ensure tha this deficiency is corrected and will not recur.	
N 0522	410 IAC 17-13-1(a	a)			
Bldg. 00	written medical pla				
	Based on record reversal failed to ensure the care to the patient at for 1 of 4 records recensure the home heronly the tasks on the the scope of their put tasks completed for services (#2). Findings include: 1. An agency polic "Physicians plan of stated " Physicians documented for the provides verbal compatient's/clients climated." 2. An agency polic health aide service, Activities a home haide will not admits a for the provides will not admits a formation of the provides and	view and interview, the agency skilled nurse did not provide been of a physician's order eviewed (#1) and failed to alth aide (HHA) completed et aide care plan that are within ractive, and document the 1 of 3 records with aide 2 dated 2/13/19 titled treatment," Policy #2.18 s' orders are established and health services [the agency] orders are to be recorded in the ical record" 2 dated 1/29/17 titled "Home 'Policy # 2.48 stated " elath aide may not perform-the inister medications change	N 0522	N-522 SN staff were educated on following a written plan of care established by a physician.SN Staff educated on Respite order must be included in the plan of care. SN staff were re-counseled that 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.	y y
	sterile dressing A client care procedur	an aide never decides which res she / he will perform. Forms onnly those activities		10% of recerts & SOC will be audited Quarterly to evidence	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K076		A. BUII B. WIN	LDING	00	COMPL 09/06/	ETED	
	PROVIDER OR SUPPLIER			10484 N	DDRESS, CITY, STATE, ZIP COD I STATE ROAD 13		
HEAVEN	SENT HOME HEA	LTH CARE LLC		ELWOO	DD, IN 46036		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	which have been as: 3. The clinical record on 9/5/19 and indicated 6/9/15. The record certification period indicated a skilled r "20 hrs [hours] mobe gone on Thursdadependent has respiepisodes when eating evidence orders for thus providing care order. During a skilled number of bed for patient out of bed for patient back into be the nurse completed patient up for lunch and took the patient. During a skilled number of lunch and took the patient out of bed for patient up for lunch and took the patient. During a skilled number of lunch took the patient outs the nurse completed patient up for lunch took the patient outs the nurse measure the nurse completed patient up for lunch took the patient outs the nurse completed patient up for lunch took the patient outs to bed.	ord of patient #1 was reviewed ated a start of care date of contained a plan of care for the of 7/18/19-9/15/19 that espite nursing frequency of [month] used when wife has to sys patient is vent ratory distress and choking ag " The record failed to the nurse to complete care, to the patient absent of an assessment, got the or 3.5 hours and put the d. The record failed to the patient absent of an assessment, got the or 3.5 hours and put the d. The record failed to the patient absent of an assessment, got the and monitored while eating, so outside. The record failed to the patient absent of an assessment, got the and monitored while eating, side, and the wife requested			physician orders were obtained and Home Health aide staff completing only tasks that are within their scope of practice wany adverse findings reported QAPI Clinical Director will be responsible for monitoring these correct actions to ensure that the deficiency is corrected and will recur	rith to se his	
	the nurse completed	I an assessment, got the and monitored while eating,					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K076		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVE COMPLETED 09/06/2019	Y	
	PROVIDER OR SUPPLIEF		10484 I	ADDRESS, CITY, STATE, ZIP CO N STATE ROAD 13 DD, IN 46036	DD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPROPRIATE	(X5) PLETION DATE
0		side and right back inside, and				
	the nurse completed	rse visit completed on 8/22/19 d an assessment, got the nd kept up 2.5 hours.				
	the nurse visited to because it was the p completed an assess	rse visit completed on 8/29/19 see how the patient was patients birthday. The nurse sment and the caregiver measure the wound.				
	on 9/5/19 and indic 1/26/17. The record the certification per	ord of patient #2 was reviewed ated a start of care date of d contained a plan of care for riod of 7/15/19-9/12/19. The plete tasks only within her evidenced by:				
	employee G, HHA, fell on 7/29/19 she patient's leg and bat 9/3/19 she cleaned	ov on 9/6/19 at 12:00 PM, stated that when the patient cleaned up the cut on the indaged it. She also stated on the cut again, applied triple and bandaged it because it				
N 0524	410 IAC 17-13-1(a	a)(1)				
Bldg. 00	Rule 13 Sec. 1(a) plan of care shall: (A) Be developed home health agen (B) Include all set skilled service is to (B) Cover all pert (C) Include the form of the control of	I in consultation with the acy staff. rvices to be provided if a being provided. inent diagnoses. Illowing:				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 B. WING		COMPLETED	
		15K076	B. W	ING		09/06/2019	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 10484 N STATE ROAD 13 ELWOOD, IN 46036				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	1	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	(iv) Prognosis. (v) Rehabilitatic (vi) Functional li (vii) Activities pe (viii) Nutritional re (ix) Medications (x) Any safety against injury. (xi) Instructions referral. (xii) Therapy mo treatment. (xiii) Any other ap Based on record re failed to ensure the pertinent treatments records reviewed. (i) Findings include: 1. An agency polic "Physicians plan of stated " A physici signed by the physi days after admissio include: The type needed specific of supplies and equipr 2. An agency polic management and as stated " Essential follows an individu 3. The clinical reco on 9/5/19 and indic	mitations. rmitted. equirements. s and treatments. measures to protect for timely discharge or dalities specifying length of opropriate items. view and interview, the agency plan of care (POC) included all s, orders, and goals in 2 of 4 #1, 2). by dated 2/13/19 titled freatment," Policy #2.18 fain's plan of treatment must be cian and in the chart within 30 in to [agency] and must e and frequency of services orders necessary medical	NO	524	N-0524 Clinical Director has educated/in-serviced nursing on N-0524 including all pertine diagnoses, treatments and measurable outcomes assessments for accurate documentation. All records cit at survey have been corrected 100% clinical records were reviewed and verbal orders obtained if needed were sent Physician to clarify any missin pertinent diagnoses, treatment and measurable goals. Measurable outcomes and go will be discussed with patient each skilled nursing encounter and documented. 50% of new admissions and 50 frecert's comprehensive assessments and Plan of Carbe audited for missing pertine	ent ed d. to ng sits sals sat or	

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PRINTED: 10/23/2019 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K076		(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCT IG <u>00</u>	TON	(X3) DATE COMP. 09/06		
	PROVIDER OR SUPPLIEF		104	EET ADDRESS, 184 N STATE WOOD, IN 46			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG	X (EACH CROSS-	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	indicated a skilled r "20 hrs [hours] mo be gone on Thursda dependent has respi episodes when eatin to evidence the nee- (orders) the nurse w home, the type of v wound care orders, needs of the patient the wound. The recertification of completed on 7/15/ respiratory status. equipment] and sup O2[oxygen] supplies stated the patient has sacrum and the wife dressing daily. 4. The clinical rece on 9/5/19 and indic 1/26/17. The recor- the certification per indicated orders for hours per moth (5 h (ATTC) Care 20 ho	ord of patient #2 was reviewed ated a start of care date of d contained a plan of care for iod of 7/15/19-9/12/19 that homemaker (HMK) for 20 ours a week), and Attendant urs per moth (5 hours a week).		measu consult addition nursing Admini months Any ad reported Clinica will be these of	irable goals x 2 mon tant for evidence of anal insight and educe g staff. Clinical directistrator will review at the second to t	eation of tor and udits x 2 changes be strator nitoring and to	
N 0533	410 IAC 17-13-2 Nursing Plan of C	ara					
Bldg. 00	Rule 13 Sec. 2(a) must be develope the purpose of de patient care providagency for patient	A nursing plan of care d by a registered nurse for legating nursing directed ded through the home health s receiving only home es in the absence of a					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15K076		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/06/2019				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 10484 N STATE ROAD 13 ELWOOD, IN 46036					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	following: (1) A plan of care identifying informa (2) The name of the control of the control of the care identifying informa (2) The name of the control of the care identifying informa (2) The name of the control of the care identifying includes (3) Services of the care in accordance with home hralth aide care in accordance of the care in according to the care in accordance of the care in according to the care in accordance of the care	the patient's physician. It is provided. It i	N 0533	N-0533 All HHA were retrained/In-ser about documenting separately when tasks are completed usi AM, Noon and PM to designar which shift it was completed. The HHA who completed this documentation incorrectly was counseled in writing to design shifts accordingly by using An Noon or PM with patients who 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 the physician for clarification. 10% of all clinical records will audited quarterly for evidence adhering to this deficiency	ing te s ate n, om /e to be			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED
		15K076	B. WI	NG	_	09/06	/2019
NAME OF T	DROLUDED OF GUREY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C		10484 N	N STATE ROAD 13		
HEAVEN	SENT HOME HEA	LTH CARE LLC		ELWOC	DD, IN 46036		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENC!)		DATE
	The clinical record	of patient #1 was reviewed on			The Administrator shall be		
		d a start of care date of 6/9/15.			responsible for monitoring the	SE	
		ed a plan of care for the			corrective actions to ensure th		
		of 7/18/19-9/15/19. The home			this deficiency is corrected an		
	_	document which shift each			will not recur		
	task was completed	, but rather just put an 'X' to					
	indicate completed						
	The agency HHA	veekly note with dated					
		cluded shifts of 9 AM-11 AM, 1					
		M-11 PM (except Saturday for					
		k on this document had 1 to 3					
	/	ne document failed to indicate					
	what shift these task	ks were completed.					
		veekly note with dated					
		cluded shifts of 9 AM-11 AM, 1					
		A-11 PM (except Saturday for ask on this document had 1 to 3					
	· · ·	ne document failed to indicate					
	what shift these task						
	what shift these task	no were compressed.					
		weekly note with dated					
		uded shifts of 9 AM-11 M, 1					
		1-11 PM (except Saturday for					
	· · ·	k on this document had 1 to 3					
		ne document failed to indicate					
	what shift these task	ks were completed.					
	The agency HHA w	veekly note with dated					
		uded shifts of 9 AM-11 M, 1					
		1-11 PM (except Saturday for					
		k on this document had 1 to 3					
	'X' on each line. Th	ne document failed to indicate					
	what shift these task	ks were completed.					
	The agency HHA w	veekly note with dated					
		cluded shifts of 9 AM-11 M, 1					
		4-11 PM (except Saturday for					

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PRINTED: 10/23/2019 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K076		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/06/2019	
	PROVIDER OR SUPPLIER		10484	ADDRESS, CITY, STATE, ZIP COD N STATE ROAD 13 DD, IN 46036	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	'X' on each line. The what shift these task	k on this document had 1 to 3 the document failed to indicate as were completed. The early note with dated luded shifts of 9 AM-11 M, 1			
	3rd shift). Each tas	I-11 PM (except Saturday for k on this document had 1 to 3 the document failed to indicate as were completed.			
	8/25/19-8/31/19 inc PM-3PM, and 9 PM 3rd shift). Each tas	reekly note with dated luded shifts of 9 AM-11 M, 1 I-11 PM (except Saturday for k on this document had 1 to 3 are document failed to indicate as were completed.			
N 0541 Bldg. 00	services are limite				
	following:	ered nurse shall do the			
	Based on record rev registered nurse (RI comprehensive asse information regardi status for 1 of 4 reco	riew, and interview, the N) failed to ensure that the essment contained all ng the patient's current health ords (#1).	N 0541	N-0541 Assistant clinical director retrained/ln-serviced on Completing a comprehensive assessment The RN whom completed this	10/04/2019
	for assessment," Po comprehensive asse	ated 1/29/17 titled "Guidelines licy # 2.05 stated " Initial essment: 1. The initial utilized by the RN for the		assessment which failed to contain all of the patients curre health status as sited in findin was counseled in writing and retrained to include all informating regarding the patients current	gation

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PRINTED: 10/23/2019 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K076		A. BUILDING B. WING	00	COMPLETED 09/06/2019	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD N STATE ROAD 13	
HEAVEN	SENT HOME HEA	LTH CARE LLC		OD, IN 46036	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		d / or assessment in order to: ed for home care and services		health status. All patients cited at survey ha	ve
	and the type of care	and services to be provided		been corrected	
		pplies and equipment required		400/ 6 11 12 1 1 1 1 1 1 1 1	
		I findings equipment needs The reassessment process is		10% of all clinical charts will be audited quarterly to adhere to	
		the client's contact with		deficiency and any adverse ef	
		nt is reassessed to determine		will be reported to the QAPI	
	the client's response				
		s: Every 60 days when the		Clinical Manager/Administrato	or will
	client is receiving se	ervices."		be responsible for monitoring	
	An agency policy dated January 2018 titled "RN			these corrective actions and to	
	clinical Manager," Policy # HC-105 stated "			ensure this deficiency is corre and will not recur	cteu
		Performs comprehensive		and will not recal	
	assessments of clien	t status, including physical			
	parameters"				
		of patient #1 was reviewed on			
		l a start of care date of 6/9/15.			
		d a plan of care for the			
	_	of 7/18/19-9/15/19 that espite nursing frequency of			
		[month] used when wife has to			
	be gone on Thursda				
	dependent has respin	ratory distress and choking			
		g " The record failed to			
		t respiratory status as			
	evidenced by:				
		comprehensive assessment			
	*	19 was blank under the			
		t failed to identify the			
	-	nds, cough, if was a smoker, opnea, hemoptysis, or			
	-	tomy information including			
		durable medical equipment]			
	and supplies it state				
	supplies." The comp	prehensive assessment failed			
	to evidence the need	ls of the patient and tasks the			

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K076		A. BUILDING 00 B. WING		COMPLETED 09/06/2019			
	PROVIDER OR SUPPLIER			10484 N	ADDRESS, CITY, STATE, ZIP COD N STATE ROAD 13 DD, IN 46036		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
N 0544 Bldg. 00	of ventilator, ventilate episodes. During an interview director of nursing soffice to see a patient patient is "a vent paralive that came off to "he is respite only." 410 IAC 17-14-1(a Scope of Services Rule 14 Sec. 1(a) services are limite purposes of practices etting, the register following: (E) Prepare clinical Based on record revergistered nurse (RN weekly for 1 of 2 parallel for the clinical record contained to the record contained certification period of the agency recertification period of the agency recertification period of the agency skilled nursing measurements on 8/4 agency skilled nursing measurements on	(1)(E) Except where d to therapy only, for ce in the home health red nurse shall do the all notes. iew, and interview, the slight of patient #1 was reviewed on a start of care date of 6/9/15. d a plan of care for the of 7/18/19-9/15/19. cation comprehensive d wound measurements on ing visit notes contained 1/19 and 8/29/19 (weeks 3 and d to evidence wound	NO	544	N-544 Clinical Director has educated/in-serviced nursing son policy and procedures for wound documentation to include wound measurements weekly. records cited at survey have be 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 be audited for missing wound measurements x 2 months by consultant for evidence of	de All een o g 0% e will	10/04/2019

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K076		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/06/2019	
NAME OF PROVIDER OR SUPPLIER HEAVEN SENT HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP COD 10484 N STATE ROAD 13 ELWOOD, IN 46036			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	director of nursing caregiver how to m back in 2015 and no	v on 9/6/19 at 3:17 PM, the stated she taught patient #1's easure and care for the wound ow the caregiver takes care of ask the DON to measure only		additional insight and education nursing staff. Clinical director administrator will review audit months to implement any characteristic and adverse findings will be reported to QAPI Clinical Director & Administrat will be responsible for monitor these corrective actions and to ensure this deficiency is correand does not recur	and is x 2 inges tor ring o	

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