PRINTED: 11/21/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LDING	ONSTRUCTION  00	(X3) DATE COMPL 11/09/	ETED	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE	F 40		
PEAK HOME HEALTH					ONNECTICUT STREET, SUIT LLVILLE, IN 46410	E AZ		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION	
TAG G0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
G0000								
	This visit was for a home health initial Medicaid certification survey. This was a		G00	000				
	partial extended	-						
	F							
	Facility: 12888							
	Medicaid Vendor #: N/A.							
	Dates of Survey 2012.	: November 7, 8, and 9,						
	Surveyor: Janet	Brandt, RN,PHNS.						
	Number of reco	rds reviewed: 05						
		ve records reviewed: 03						
		ed records reviewed: 02.						
	Quality Review:	: Joyce Elder, MSN, BSN,						
	RN	• , , ,						
	No	vember 13, 2012						
		•						

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LDING	00	(X3) DATE S COMPL 11/09/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  8684 CONNECTICUT STREET, SUITE A2  MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES 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)	ſE	(X5) COMPLETION DATE
G0101	his or her rights. promote the exerce based on medicareview and intervensure the patient charges, anticipal patient liability, apayment as ident for 5 of 5 records potential to affect patients. (#1-5)  Findings include  1. "Patient Admundated, policy sold / caregiver of the procedures and, anticipated insurpatient / caregive other methods of patient's signature. Agreement, Homand other forms and other forms."  2. Medical recordailed to evidence patient was informatical insurpatient.	the right to be informed of The HHA must protect and cise of those rights.  If record and policy view, the agency failed to it was advised of the ted insurance coverage, and other methods of iffied in the agency policy is reviewed with the it all the agency's  ::  ission Process C-140", states, "Advise the patient is charges and billing to the extent possible, the ance coverage, the er financial liability, and is payment Obtain the is on the Service in Care Bill of Rights, required by the agency."  If #1, SOC 11-1-12, the documentation the med of the patient is patient rights document	G01	101	G101 The Administrator has prepared a letter that will be so via certified mail to all patients that have received home healt care services. The letter will reflect that the patient nor the patient's insurance will be billed, that the only services currently being provided are skilled nursing and physical therapy, and that we are not currently a Medicare certified agency. A copy of the letter alo with the signature of receipt will be placed in each patient's medical record. All future patient will receive a written letter that they will sign to verify that they received the appropriate information. The patient orientation hanbook will be modified to reflect that the patinor the patient's insurance will billed and that the only service currently being provided areskilled nursing and physical therapy. The agency Administrativill be responsible for institutinal monitoring these correctivactions to ensure that this deficiency is adequately correct and will not reocurr.	ong II ents s eator	11/19/2012

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Event ID: 8GD411

Facility ID: 012888

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE COMPI	LETED			
			B. WING		11/09	/2012		
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP CODE  8684 CONNECTICUT STREET, SUITE A2  MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	failed to evidence patient was information	rd #2, SOC 10-28-12, the documentation the strength of the patient me patient rights document by.						
	failed to evidence patient was information	rd #3, SOC 10-12-12, the documentation the strength of the patient are patient rights document by.						
	failed to evidence patient was information	d #4, SOC 10-11-12, the documentation the trimed of the patient the patient rights document by.						
	failed to evidence patient was information	d #5, SOC 08-24-12, the documentation the rmed of the patient the patient rights document by.						
	11/9/12 at 2:00 I indicated that pa agency under the were told that the services of the agof benefits signed used to obtain paindicated there v	w with Employee A on PM CST, Employee A tients admitted to the e provisional state license ere was no charge for the gency and the assignment d by the patients were not ayment. Employee A was no documentation that e told what their financial						

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING B. WING	00				
	PROVIDER OR SUPPLIER  OME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE  8684 CONNECTICUT STREET, SUITE A2  MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
	obligation to the agency was.						

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Event ID: 8GD411

Facility ID: 012888

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
			B. WIN		<del></del>	11/09/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ONNECTICUT STREET, SUITE	Δ2	
PEAK HO	OME HEALTH				LLVILLE, IN 46410	AZ	
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		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 APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
G0113	The patient has the before care is inition payment for the Hexpected from Meand the extent to required from the Based on medicareview and intervensure the patient charges, anticipal patient liability, apayment for 5 of the potential to a patients. (#1-5)  Findings include  1. "Patient Admundated, policy so are giver of the procedures and, the anticipated insurpatient / caregiver other methods of patient's signature. Agreement, Homand other forms to the patient of the patient of the patient of the patient of the patient. Howard other forms to the patient was information to the patient was informaticipated insurpatient was informatically the patient of the patient of the patient was informatically the payment of the patient was informatically the patient was informatically the payment of the patient was informatically the payment of the patient was informatically the patient was informatically the patient was informatically the payment of the patient was informatically the payment of the patient was informatically the payment of the patient was informatically the patient was informatically the payment of the patient of the pa	al record and policy view, the agency failed to at was advised of the ted insurance coverage, and other methods of 5 records reviewed with agency's states, "Advise the patient e charges and billing to the extent possible, the ance coverage, the er financial liability, and apayment Obtain the even the Service are Care Bill of Rights, required by the agency."	G01	.13	G113 The Administrator has prepared a letter that will be se via certified mail to all patients that have received home healt care services. The letter will reflect that the patient nor the patient's insurance will be billed, that the only services currently being provided are skilled nursing and physical therapy, and that we are not currently a Medicare certified agency. A copy of the letter alc with the signature of receipt wi be placed in each patient's medical record. All future patie will receive a written letter that they will sign to verify that they received the appropriate information. The patient orientation hanbook will be modified to reflect that the patinor the patient's insurance will billed and that the only service currently being provided areskilled nursing and physical therapy. The agency Administrator will be responsibe for instituting and monitoring these corrective actions toensuthat this deficiency is adequate correct and will not reocurr.	ong II nts ent be s I	11/19/2012

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Event ID: 8GD411

Facility ID: 012888

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION  00	(X3) DATE COMPL 11/09/	ETED		
	PROVIDER OR SUPPLIER		B. WING 11709/2012  STREET ADDRESS, CITY, STATE, ZIP CODE  8684 CONNECTICUT STREET, SUITE A2  MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	failed to evidence patient was information	rd #2, SOC 10-28-12, e documentation the rmed of the patient re patient rights document by.					
	failed to evidence patient was information	rd #3, SOC 10-12-12, e documentation the rmed of the patient he patient rights document by.					
	failed to evidence patient was infor	d #4, SOC 10-11-12, e documentation the med of the patient he patient rights document by.					
	failed to evidence patient was infor	d #5, SOC 08-24-12, e documentation the rmed of the patient he patient rights document by.					
	11/9/12 at 2:00 If indicated that pa agency under the were told that the services of the agof benefits signed used to obtain page 11/9/12 at 2:00 If indicated that the services of the agof benefits signed used to obtain page 11/9/12 at 2:00 If indicated that the services of the agof benefits signed used to obtain page 11/9/12 at 2:00 If indicated that the services of the agof benefits signed used to obtain page 11/9/12 at 2:00 If indicated that the services of the agof 11/9/12 at 2:00 If indicated that the services of the agof 11/9/12 at 2:00 If indicated that the services of the agof 11/9/12 at 2:00 If indicated that the services of the agof 11/9/12 at 2:00 If indicated that a constant indicated the agof 11/9/12 at 2:00 If indicated t	w with Employee A on PM CST, Employee A tients admitted to the e provisional state license ere was no charge for the gency and the assignment d by the patients were not syment. Employee A was no documentation that					

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	TO OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMI	e survey Pleted 9/2012		
	PROVIDER OR SUPPLIER  DME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE  8684 CONNECTICUT STREET, SUITE A2  MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
TAG	the patients were told what their financial obligation to the agency was.	TAG	DEFICIENCY		DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED			
			B. WING		11/09/2012		
NAME OF PROVIDER OR SUPPLIER PEAK HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE  8684 CONNECTICUT STREET, SUITE A2  MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES 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		
G0114	Before the care is inform the patient (i) The extent to vexpected from Moother Federally further with the patient (ii) The charges for covered by Medical (iii) The charges for to pay.  Based on medical review and interest the patient charges, anticipal patient liability, payment for 5 of the potential to a patients. (#1-5)  Findings includes 1. "Patient Admundated, policy so are giver of the procedures and, anticipated insurpatient / caregiver of the procedures and, anticipated insurpatient / caregiver of the patient's signature Agreement, Hon and other forms so a second control of the procedure of the patient's signature Agreement, Hon and other forms so a second control of the patient's signature Agreement, Hon and other forms so a second control of the patient's signature Agreement, Hon and other forms so a second control of the patient's signature Agreement, Hon and other forms so a second control of the patient's signature Agreement, Hon and other forms so a second control of the patient's signature Agreement, Hon and other forms so a second control of the patient's signature Agreement, Hon and other forms so a second control of the patient's signature Agreement, Hon and other forms so a second control of the patient's signature Agreement and the patient's sign	or services that will not be care; and hat the individual may have all record and policy view, the agency failed to ut was advised of the ted insurance coverage, and other methods of 5 records reviewed with agency's  :  ission Process C-140", states, "Advise the patient e charges and billing to the extent possible, the ance coverage, the er financial liability, and a payment Obtain the	G0114	G114 The Administrator has prepared a letter that will be s via certified mail to all patients that have received home heal care services. The letter will reflect that the patient nor the patient's insurance will be billed, that the only services currently being provided are skilled nursing and physical therapy, and that we are not currently a Medicare certified agency. A copy of the letter al with the signature of receipt w be placed in each patient's medical record. All future patie will receive a written letter that they will sign to verify that the received the appropriate information. The patient orientation hanbook will be modified to reflect that the patient that the patient's insurance will billed and that the only service currently being provided areskilled nursing and physical therapy. The agency Administrator will be responsil for instituting and monitoring these corrective actions toens	ong ill ents t y ient l be es		

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Event ID: 8GD411

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU: A. BUILI		NSTRUCTION 00	(X3) DATE S	ETED	
			B. WING			11/09/	ZU1Z
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  8684 CONNECTICUT STREET, SUITE A2  MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	patient was informed of the patient liability as per the patient rights document and agency policy.				that this deficiency is adequate correct and will not reocurr.	ely	
	failed to evidence patient was infor	rd #2, SOC 10-28-12, e documentation the rmed of the patient he patient rights document by.					
	failed to evidenc patient was infor	rd #3, SOC 10-12-12, e documentation the rmed of the patient e patient rights document cy.					
	failed to evidence patient was infor	d #4, SOC 10-11-12, e documentation the rmed of the patient re patient rights document cy.					
	failed to evidence patient was infor	d #5, SOC 08-24-12, e documentation the rmed of the patient he patient rights document by.					
	11/9/12 at 2:00 F indicated that pa agency under the were told that the	w with Employee A on PM CST, Employee A tients admitted to the provisional state license ere was no charge for the gency and the assignment					

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	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING B. WING	00 	COMPLETED 11/09/2012			
	PROVIDER OR SUPPLIER  OME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE  8684 CONNECTICUT STREET, SUITE A2  MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	of benefits signed by the patients were not used to obtain payment. Employee A indicated there was no documentation that the patients were told what their financial obligation to the agency was.						

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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. BUII	DING	00	COMPLETED	
			B. WIN		<del></del>	11/09/	2012
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ONNECTICUT STREET, SUITE	Δ2	
PEAK HO	OME HEALTH				LLVILLE, IN 46410	712	
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		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 APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
G0135	supervising physi required under parensures the accumaterials and actions. Based on admiss interview, the adrensure the admissions were accurate for potential to affect agency.  Findings include  1. The admissions Employee B on the CST as the agency identified the agency services, skilled the health aide services peech therapy, at the home.  2. In an interview AM CST, Employee B, the social work services with the social work services and physical there.	c, who may also be the cian or registered nurse tragraph (d) of this section, racy of public information ivities.  ion packet review and ministrator failed to sion packet documents of 1 of 1 agency with the stall patients of the  :  In packet, presented by 11-7-12 at 11:00 AM cy's admission packet, ency offered social nursing services, home ces, occupational therapy, and physical therapy in  w on 11-7-12 at 11:30 oyee B indicated the killed nursing services rapy services. Per agency did not offer ices, occupational therapy therapy services, or home	G011	35	G135 The Administrator has prepared a letter that will be so via certified mail to all patients that have received home healt care services. The letter will reflect that the patient nor the patient's insurance will be billed, that the only services currently being provided are skilled nursing and physical therapy, and that we are not currently a Medicare certified agency. A copy of the letter all with the signature of receipt wibe placed in each patient's medical record. All future patie will receive a written letter that they will sign to verify that they received the appropriate information. The patient orientation hanbook will be modified to reflect that the patinor the patient's insurance will billed and that the only service currently being provided areskilled nursing and physical therapy. The agency Administrator will be responsible for instituting and monitoring these corrective actions toens that this deficiency is adequate correct and will not reocurr.	ong II nts ent be s I	11/19/2012

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STATEMENT OF DEFICIENCIES X1) PROVII		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CON	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	7	00	COMPL	ETED
			A. BUILDING B. WING	J		11/09/	2012
				DEET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹	8684 CONNECTICUT STREET, SUITE A2				
					•	AZ	
PEAK HOME HEALTH		IVIE	ERRIL	LVILLE, IN 46410			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREF	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	G	DEFICIENCY)		DATE
N0000	Facility #: 1288  Dates of Survey: 2012.	8. November 7, 8, and 9,	N0000				
	-	Brandt, RN, PHNS					
	Number of recor	rds reviewed: 05					
	Number of activ	re records reviewed: 03					
	Number of close	ed records reviewed: 02.					
	Quality Review: RN	Joyce Elder, MSN, BSN,					
	Nov	vember 13, 2012					
		•					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/09/2012		
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ONNECTICUT STREET, SUITE	: ^2	
PEAK HO	OME HEALTH				LLVILLE, IN 46410	. 72	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
N0447	who may also be or registered nurs (d), shall do the fe (4) Ensure the adinformation mater Based on admissinterview, the adensure the admission were accurate for potential to affect agency.  Findings includes 1. The admission Employee B on CST as the agency identified the agreement of the agreement of the although the although the although the agency of the service of the agency of the service of the agency of the service of the agency of the agency of the agency of the service of the agency of the agency of the agency of the service of the agency of the agen	anagement ()(4) The administrator, the supervising physician se required by subsection collowing: couracy of public rials and activities. cion packet review and ministrator failed to sion packet documents or 1 of 1 agency with the et all patients of the  11-7-12 at 11:00 AM cy's admission packet, ency offered social nursing services, home ces, occupational therapy, and physical therapy in  w on 11-7-12 at 11:30 cyce B indicated the killed nursing services rapy services. Per ragency did not offer ices, occupational therapy therapy services, or home	N04	147	N447 The Administrator has prepared a letter that will be so via certified mail to all patients that have received home healt care services. The letter will reflect that the patient nor the patient's insurance will be billed, that the only services currently being provided are skilled nursing and physical therapy, and that we are not currently a Medicare certified agency. A copy of the letter ale with the signature of receipt wibe placed in each patient's medical record. All future patie will receive a written letter that they will sign to verify that they received the appropriate information. The patient orientation hanbook will be modified to reflect that the patinor the patient's insurance will billed and that the only service currently being provided areskilled nursing and physical therapy. The agency Administrator will be responsite for instituting and monitoring these corrective actions toens that this deficiency is adequate correct and will not reocurr.	ong iill ents i fent be es	11/19/2012

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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		00	COMPLETED			
	B. WING			11/09/	2012			
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
While of TROVIDER OR SOTTEMEN			8684 CONNECTICUT STREET, SUITE A2					
PEAK HO	OME HEALTH			MERRI	LLVILLE, IN 46410			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX			PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
N0494	410 IAC 17-12-3(a)(1)&(2)							
	Patient Rights	) The patient or the						
		presentative has the right to						
		e patient's rights through						
		of communication. The						
		ncy must protect and						
		cise of these rights and						
	shall do the follow	oatient with a written notice						
	of the patient's rig							
		f furnishing care to the						
	patient; or							
	· '	tial evaluation visit before						
	the initiation of tre	eatment. cumentation showing that it						
		n the requirements of this						
	section.							
			N04	194	N494 The Administrator has		11/19/2012	
	Based on medical record and policy				prepared a letter that will be se			
	review and inter	view, the agency failed to			via certified mail to all patients			
	ensure the patient was advised of the charges, anticipated insurance coverage, patient liability, and other methods of payment as identified in the agency policy for 5 of 5 records reviewed with the potential to affect all the agency's				that have received home healt care services. The letter will	.11		
					reflect that the patient nor the			
					patient's insurance will be			
					billed,that the only services			
					currently being provided are skilled nursing and physical			
					therapy, and that we are not			
	patients. (#1-5)				currently a Medicare certified			
					agency. A copy of the letter al	•		
	Findings include	<b>:</b>			with the signature of receipt w be placed in each patient's	III		
					medical record. All future patie	ents		
	1. "Patient Adm	ission Process C-140",			will receive a written letter that	:		
	undated, policy states, "Advise the patient				they will sign to verify that they	/		
		e charges and billing			received the appropriate information. The patient			
	_	to the extent possible, the			orientation hanbook will be			
	•	ance coverage, the			modified to reflect that the pati	ient		
	patient / caregiver financial liability, and				nor the patient's insurance will			
					billed and that the only service	es		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
			B. WING			11/09/	2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				8684 C	ONNECTICUT STREET, SUITE	A2	
PEAK HOME HEALTH			MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY S'	FATEMENT OF DEFICIENCIES		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 APPROPRIAT	TE .	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	other methods of	payment Obtain the			currently being provided		
	patient's signatur	re on the Service			areskilled nursing and physica		
	Agreement, Hon	ne Care Bill of Rights,			therapy. The agency Administrator will be responsib	Jo.	
	•	required by the agency."			for instituting and monitoring	ii C	
		and the state of t			these corrective actions toens	ıre	
	2 Medical reco	rd #1, SOC 11-1-12,			that this deficiency is adequate		
		e documentation the			correct and will not reocurr.	-	
	_	med of the patient					
		e patient rights document					
	and agency policy.						
		rd #2, SOC 10-28-12,					
	failed to evidenc	e documentation the					
	patient was infor	med of the patient					
	liability as per th	e patient rights document					
	and agency polic						
		<b>3</b> ·					
	4 Medical reco	rd #3, SOC 10-12-12,					
		e documentation the					
	patient was informed of the patient liability as per the patient rights document and agency policy.						
	5 Madical	1 #4 COC 10 11 12					
		d #4, SOC 10-11-12,					
		e documentation the					
	1 *	med of the patient					
		e patient rights document					
	and agency polic	y.					
		d #5, SOC 08-24-12,					
	failed to evidence	e documentation the					
	patient was informed of the patient liability as per the patient rights document						
	and agency police	-					
	Bone, pone	J :					

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 11/09/2012			
NAME OF PROVIDER OR SUPPLIER PEAK HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE  8684 CONNECTICUT STREET, SUITE A2  MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	(X5) COMPLETION DATE			
	11/9/12 at 2:00 F indicated that pa agency under the were told that the services of the ag of benefits signe used to obtain pa indicated there w	w with Employee A on PM CST, Employee A tients admitted to the provisional state license ere was no charge for the gency and the assignment d by the patients were not syment. Employee A vas no documentation that e told what their financial agency was.						

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