PRINTED: 02/14/2012 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                   | (X2) MULTIPLE CONSTRUCTION     |             | (X3) DATE SURVEY                                            |            |  |
|------------------------------------------------------|-----------------------------------|--------------------------------|-------------|-------------------------------------------------------------|------------|--|
| AND PLAN                                             | OF CORRECTION                     | IDENTIFICATION NUMBER:         |             | 00                                                          | COMPLETED  |  |
|                                                      |                                   | 15K076                         | A. BUILDING |                                                             | 01/27/2012 |  |
|                                                      |                                   | 10.10.10                       | B. WING     |                                                             | 01/21/2012 |  |
| NAME OF F                                            | PROVIDER OR SUPPLIE               | ER                             |             | ADDRESS, CITY, STATE, ZIP CODE                              |            |  |
|                                                      |                                   |                                |             | ANDERSON ST                                                 |            |  |
| HEAVEN                                               | HEAVEN SENT HOME HEALTH CARE LLC  |                                | ELWO        |                                                             |            |  |
| (X4) ID                                              | SUMMARY STATEMENT OF DEFICIENCIES |                                | ID          | PROVIDER'S PLAN OF CORRECTION                               | (X5)       |  |
| PREFIX                                               | (EACH DEFICIE                     | NCY MUST BE PERCEDED BY FULL   | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE                           | COMPLETION |  |
| TAG                                                  | REGULATORY O                      | R LSC IDENTIFYING INFORMATION) | TAG         | TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         |            |  |
| G0000                                                |                                   |                                |             |                                                             |            |  |
| ]                                                    |                                   |                                |             | l                                                           |            |  |
|                                                      | This was a federal ho             | me heatlh complaint            | G0000       | N0000 - Heaven Sent Home                                    |            |  |
|                                                      |                                   | -                              |             | Health Care LLC takes regula                                | -          |  |
|                                                      | investigation.                    |                                |             | compliance very seriously. The                              |            |  |
|                                                      |                                   |                                |             | plan of correction is to serve a our credible allegation of | as         |  |
|                                                      | Complaint # IN 001                | 02734: Substantiated:          |             | compliance.                                                 |            |  |
|                                                      |                                   | lated to the allegation        |             | compliance.                                                 |            |  |
|                                                      |                                   | lated to the allegation        |             |                                                             |            |  |
|                                                      | are cited.                        |                                |             |                                                             |            |  |
|                                                      |                                   |                                |             |                                                             |            |  |
|                                                      |                                   | 27, 2042                       |             |                                                             |            |  |
|                                                      | Survey Date: Januar               | y 27, 2012                     |             |                                                             |            |  |
|                                                      |                                   |                                |             |                                                             |            |  |
|                                                      | Facility #: 012612                |                                |             |                                                             |            |  |
|                                                      | 1 acmty #. 012012                 |                                |             |                                                             |            |  |
|                                                      |                                   |                                |             |                                                             |            |  |
|                                                      | Medicaid Vendor #:                | Application                    |             |                                                             |            |  |
|                                                      |                                   |                                |             |                                                             |            |  |
|                                                      |                                   |                                |             |                                                             |            |  |
|                                                      | Surveyor: Bridget B               | oston, RN, PHNS                |             |                                                             |            |  |
|                                                      |                                   |                                |             |                                                             |            |  |
|                                                      | O I's B                           | Ell MCNI DONI                  |             |                                                             |            |  |
|                                                      | Quality Review: Joy               | ce Elder, MSN, BSN,            |             |                                                             |            |  |
|                                                      | RN                                |                                |             |                                                             |            |  |
|                                                      | Feb                               | ruary 2, 2012                  |             |                                                             |            |  |
|                                                      |                                   | , <b>-</b> , <b>-</b> 0.2      |             |                                                             |            |  |
|                                                      |                                   |                                |             |                                                             |            |  |
|                                                      |                                   |                                |             |                                                             |            |  |
|                                                      |                                   |                                |             |                                                             |            |  |
|                                                      |                                   |                                |             |                                                             |            |  |

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 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.

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C |                                                                             | X1) PROVIDER/SUPPLIER/CLIA                                | (X2) MULTIPLE CONSTRUCTION    |               | (X3) DATE SURVEY                                                                       |            |                  |
|---------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------|---------------|----------------------------------------------------------------------------------------|------------|------------------|
| AND PLAN                                          | OF CORRECTION                                                               | IDENTIFICATION NUMBER:                                    | A. BUILDING 00                |               |                                                                                        | COMPLETED  |                  |
|                                                   |                                                                             | 15K076                                                    | B. WIN                        |               |                                                                                        | 01/27/2012 | 2                |
| NAME OF F                                         | PROVIDER OR SUPPLIER                                                        |                                                           |                               | STREET A      | ADDRESS, CITY, STATE, ZIP CODE                                                         |            |                  |
|                                                   |                                                                             |                                                           |                               |               | ANDERSON ST                                                                            |            |                  |
| HEAVEN                                            | SENT HOME HEA                                                               | LTH CARE LLC                                              |                               | ELWO          | DD, IN 46036                                                                           |            |                  |
| (X4) ID                                           | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL |                                                           |                               | ID            | PROVIDER'S PLAN OF CORRECTION                                                          |            | (X5)             |
| PREFIX<br>TAG                                     | `                                                                           | CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION) |                               | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE.        | MPLETION<br>DATE |
| G0107                                             |                                                                             | /estigate complaints made                                 | +                             | TAG           | Dia relation,                                                                          |            | DATE             |
| 00107                                             |                                                                             | patient's family or                                       |                               |               |                                                                                        |            |                  |
|                                                   |                                                                             | g treatment or care that is                               |                               |               |                                                                                        |            |                  |
|                                                   |                                                                             | nished, or regarding the                                  |                               |               |                                                                                        |            |                  |
|                                                   | -                                                                           | the patient's property by                                 |                               |               |                                                                                        |            |                  |
|                                                   |                                                                             | services on behalf of the ocument both the existence      |                               |               |                                                                                        |            |                  |
|                                                   |                                                                             | nd the resolution of the                                  |                               |               |                                                                                        |            |                  |
|                                                   | complaint.                                                                  |                                                           | l                             |               |                                                                                        |            |                  |
|                                                   |                                                                             |                                                           | G0107 G0107 - Heaven Sent has |               |                                                                                        | /08/2012   |                  |
|                                                   | Based on clinical                                                           | l record and policy                                       |                               |               | conducted an investigation into                                                        | )          |                  |
|                                                   | review and inter-                                                           | view, the agency failed to                                |                               |               | deficiency. Further, we have fu                                                        | ıllv       |                  |
|                                                   | ensure all compl                                                            | aints regarding a lack of                                 |                               |               | documented in our complaint I                                                          |            |                  |
|                                                   | respect for patier                                                          | nt's property were                                        |                               |               | and cooperated with state office                                                       | cials      |                  |
|                                                   |                                                                             | (#7) of 3 clinical records                                |                               |               | to ensure a proper resolution i                                                        |            |                  |
|                                                   | reviewed with th                                                            | e potential to affect all of                              |                               |               | found for the patient Heaven<br>Sent will ensure all complaints                        |            |                  |
|                                                   | the patients serve                                                          | ed by the agency.                                         |                               |               | information obtained by staff o                                                        |            |                  |
|                                                   | •                                                                           |                                                           |                               |               | management is documented a                                                             |            |                  |
|                                                   | Findings include                                                            | :                                                         |                               |               | investigated Heaven Sent wil                                                           |            |                  |
|                                                   |                                                                             |                                                           |                               |               | design and document a suitab                                                           | ie         |                  |
|                                                   | 1. On 1/27/12 at                                                            | t 11:15 AM, the                                           |                               |               | action plan, based on the information gathered during th                               | e          |                  |
|                                                   |                                                                             | irector of nursing (ADM                                   |                               |               | investigation Heaven Sent w                                                            |            |                  |
|                                                   |                                                                             | d the agency had no                                       |                               |               | contact the proper state officia                                                       | ls if      |                  |
|                                                   | · · ·                                                                       | ot for one which she                                      |                               |               | one of our employees is                                                                | vint       |                  |
|                                                   |                                                                             | t documented and was                                      |                               |               | specifically named in a complate - Heaven Sent will maintain                           | mit.       |                  |
|                                                   | not investigated.                                                           | She stated, "I am sure it                                 |                               |               | on-going compliance by                                                                 |            |                  |
|                                                   | •                                                                           | ne] since I discharged                                    |                               |               | conducting complaint log audit                                                         |            |                  |
|                                                   |                                                                             | cated the power of                                        |                               |               | every quarter and conducting                                                           |            |                  |
|                                                   |                                                                             | for patient # 7 called the                                |                               |               | annual client satisfaction surve<br>The Administrator will be                          | ;y         |                  |
|                                                   |                                                                             |                                                           |                               |               | responsible for correction and                                                         |            |                  |
|                                                   | agency, approximately December 19, 2011, and requested and named two        |                                                           |                               |               | maintaining compliance.                                                                |            |                  |
|                                                   | -                                                                           | re rendering care, no                                     |                               |               |                                                                                        |            |                  |
|                                                   |                                                                             | the patient's home and                                    |                               |               |                                                                                        |            |                  |
|                                                   | _                                                                           | why. The staff members                                    |                               |               |                                                                                        |            |                  |
|                                                   |                                                                             | ployee C and another                                      |                               |               |                                                                                        |            |                  |
|                                                   | person that was i                                                           | -                                                         |                               |               |                                                                                        |            |                  |

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

Event ID: 28IS11

Facility ID: 012612

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K076 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ĺ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | LDING | NSTRUCTION  00      | (X3) DATE<br>COMPL<br>01/27                                                                                           | ETED |                            |
|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|---------------------|-----------------------------------------------------------------------------------------------------------------------|------|----------------------------|
|                                                                                                            | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |       | 211 S A             | NDDRESS, CITY, STATE, ZIP CODE<br>NDERSON ST<br>DD, IN 46036                                                          | •    |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                   | (EACH DEFICIEN<br>REGULATORY OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | ATE  | (X5)<br>COMPLETION<br>DATE |
|                                                                                                            | DON indicated ethe patient's POA of stealing" monthe patient. She agency was not shours a day, they responsible. She agency did not hand the person may were working for agency in which works. The ADA did not have any evidence the accibeen acknowledgagency.  3. Clinical recort 11/1/11, included certification perint 12/29/11 with or once a month and 13 hours a night. The clinical record employee L, a rethe sitter services PM on 11/1/11 the 11/1/11 through record failed to einvestigation was | mployee C informed her a "had accused the aides ey and possessions from indicated that since the taffing the patient 24 could not be further indicated this ave any aides in the home amed and employee C ranother home health the ADM / DON also M / DON indicated she documentation to usation or complaint had ged or investigated by the ders for a skilled nurse d for a home health aide as a sitter, 7 days a week. The devidenced that only gistered nurse, provided a from this agency from 7 arough 8 AM daily from 12/27/11. The clinical evidence any complaint or a conducted when aght the issue to the |       |                     |                                                                                                                       |      |                            |

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Event ID: 28IS11

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|                          | of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 15K076                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CO  A. BUILDING  B. WING | 00                                                                                                      | COMP<br>01/27 | E SURVEY<br>PLETED<br>7/2012 |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|---------------------------------------------------------------------------------------------------------|---------------|------------------------------|
|                          | PROVIDER OR SUPPLIER  SENT HOME HEALTH CARE LLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 211 S A                                | ADDRESS, CITY, STATE, ZIP COE<br>ANDERSON ST<br>DD, IN 46036                                            | DE            |                              |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | ILD BE        | (X5)<br>COMPLETION<br>DATE   |
|                          | attention of the administrator / director of nursing.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                        |                                                                                                         |               |                              |
|                          | 4. The undated policy titled "Complaint Policy" states, "If a complaint is voiced during a home visit the staff member is asked to document the problem and the resolution in the progress note. If the problem cannot be resolved to the patient's satisfaction by the case manager then a formal grievance process will be initiated Agency will maintain a log to document complaints. The log will include the date of the receipt, name of the individual registering the complaint, nature of the complaint, action taken and the resolution date, time and type of response Complaints will be addressed within 72 hours The director of nursing will conduct an investigation and respond to the patient or designee within 24 hours. The investigation and action taken will be documented an the complaint form." |                                        |                                                                                                         |               |                              |

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

Event ID: 28IS11

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                         | (X2) MULTIPLE CONSTRUCTION     |         |                | (X3) DATE SURVEY                                 |            |            |  |
|------------------------------------------------------|-------------------------|--------------------------------|---------|----------------|--------------------------------------------------|------------|------------|--|
| AND PLAN                                             | OF CORRECTION           | IDENTIFICATION NUMBER:         | A DIJII | A. BUILDING 00 |                                                  |            | COMPLETED  |  |
|                                                      |                         | 15K076                         | B. WING |                |                                                  | 01/27/2012 |            |  |
|                                                      |                         |                                | B. WIN  |                | ADDRESS STATE STATE SORE                         |            |            |  |
| NAME OF F                                            | PROVIDER OR SUPPLIE     | R                              |         |                | ADDRESS, CITY, STATE, ZIP CODE                   |            |            |  |
|                                                      |                         |                                |         | NDERSON ST     |                                                  |            |            |  |
| HEAVEN                                               | SENT HOME HEA           | ALTH CARE LLC                  |         | ELWOC          | DD, IN 46036                                     |            |            |  |
| (X4) ID                                              | SUMMARY S               | STATEMENT OF DEFICIENCIES      |         | ID             | PROVIDER'S PLAN OF CORRECTION                    |            | (X5)       |  |
| PREFIX                                               | (EACH DEFICIE)          | NCY MUST BE PERCEDED BY FULL   |         | PREFIX         | (EACH CORRECTIVE ACTION SHOULD BE                | TE         | COMPLETION |  |
| TAG                                                  | REGULATORY O            | R LSC IDENTIFYING INFORMATION) |         | TAG            | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) |            | DATE       |  |
| N0000                                                |                         |                                |         |                |                                                  |            |            |  |
|                                                      |                         |                                |         |                |                                                  |            |            |  |
|                                                      | This was a home heal    | th state complaint             | N00     | 00             | N0000 - Heaven Sent Home                         |            | ,          |  |
|                                                      |                         | on state companie              |         |                | Health Care LLC takes regula                     | tory       |            |  |
|                                                      | investigation.          |                                |         |                | compliance very seriously. Th                    |            |            |  |
|                                                      |                         |                                |         |                | plan of correction is to serve a                 | IS         |            |  |
|                                                      |                         |                                |         |                | our credible allegation of                       |            |            |  |
|                                                      | Complaint # IN 0010     | 02734: Substantiated:          |         |                | compliance.                                      |            |            |  |
|                                                      | State deficiencies rela | ted to the allegation          |         |                |                                                  |            |            |  |
|                                                      | are cited.              |                                |         |                |                                                  |            |            |  |
|                                                      |                         |                                |         |                |                                                  |            |            |  |
|                                                      |                         |                                |         |                |                                                  |            |            |  |
|                                                      | Survey Date: January    | 27, 2012                       |         |                |                                                  |            |            |  |
|                                                      |                         |                                |         |                |                                                  |            |            |  |
|                                                      |                         |                                |         |                |                                                  |            |            |  |
|                                                      | Facility #: 012612      |                                |         |                |                                                  |            |            |  |
|                                                      |                         |                                |         |                |                                                  |            |            |  |
|                                                      |                         |                                |         |                |                                                  |            |            |  |
|                                                      | Medicaid Vendor #:      | Application                    |         |                |                                                  |            |            |  |
|                                                      |                         |                                |         |                |                                                  |            |            |  |
|                                                      |                         |                                |         |                |                                                  |            |            |  |
|                                                      | Surveyor: Bridget Bo    | oston, RN, PHNS                |         |                |                                                  |            |            |  |
|                                                      |                         |                                |         |                |                                                  |            |            |  |
|                                                      |                         |                                |         |                |                                                  |            |            |  |
|                                                      | Quality Review: Joyo    | ce Elder, MSN, BSN,            |         |                |                                                  |            |            |  |
|                                                      | RN                      |                                |         |                |                                                  |            |            |  |
|                                                      | Feb                     | ruary 2, 2012                  |         |                |                                                  |            |            |  |
|                                                      | i coi                   | _,                             |         |                |                                                  |            |            |  |
|                                                      |                         |                                |         |                |                                                  |            |            |  |
|                                                      | l                       |                                | - 1     |                |                                                  |            | l          |  |

State Form Event ID: 28|S11 Facility ID: 012612 If continuation sheet Page 5 of 8

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| STATEMENT OF DEFICIENCIES         |                                                                             | X1) PROVIDER/SUPPLIER/CLIA    | (X2) MULTIPLE CONSTRUCTION (X3) DA |                                 | (X3) DATE S                                                                            | 3) DATE SURVEY |            |  |
|-----------------------------------|-----------------------------------------------------------------------------|-------------------------------|------------------------------------|---------------------------------|----------------------------------------------------------------------------------------|----------------|------------|--|
| AND PLAN                          | OF CORRECTION                                                               | IDENTIFICATION NUMBER:        | A. BUILDING 00                     |                                 | 00                                                                                     | COMPLETED      |            |  |
|                                   |                                                                             | 15K076                        | B. WING                            | -                               |                                                                                        | 01/27/         | 2012       |  |
| NAME OF B                         | DOWNER OF CURRINE                                                           |                               | _                                  | REET AD                         | DRESS, CITY, STATE, ZIP CODE                                                           |                |            |  |
| NAME OF P                         | PROVIDER OR SUPPLIER                                                        |                               | 21                                 | 1 S AN                          | IDERSON ST                                                                             |                |            |  |
| HEAVEN                            | SENT HOME HEA                                                               | LTH CARE LLC                  | ELWOOD, IN 46036                   |                                 |                                                                                        |                |            |  |
| (X4) ID                           | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL |                               | ID                                 |                                 | PROVIDER'S PLAN OF CORRECTION                                                          |                | (X5)       |  |
| PREFIX<br>TAG                     | `                                                                           |                               | PREFIX<br>TAG                      |                                 | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE             | COMPLETION |  |
| N0514                             |                                                                             | LSC IDENTIFYING INFORMATION)  | IAC                                | 6                               | BEFFERET                                                                               |                | DATE       |  |
| 110014                            | Rule 12 Sec. 3(c) (c) The home health agency shall do the                   |                               |                                    |                                 |                                                                                        |                |            |  |
|                                   | following:                                                                  |                               |                                    |                                 |                                                                                        |                |            |  |
|                                   |                                                                             | omplaints made by a           |                                    |                                 |                                                                                        |                |            |  |
|                                   |                                                                             | ent's family or legal         |                                    |                                 |                                                                                        |                |            |  |
|                                   | representative reg following:                                               | arding either of the          |                                    |                                 |                                                                                        |                |            |  |
|                                   | •                                                                           | care that is (or fails to be) |                                    |                                 |                                                                                        |                |            |  |
|                                   | furnished.                                                                  |                               |                                    |                                 |                                                                                        |                |            |  |
|                                   | (B) The lack of r                                                           |                               |                                    |                                 |                                                                                        |                |            |  |
|                                   | property by anyon                                                           |                               |                                    |                                 |                                                                                        |                |            |  |
|                                   | behalf of the home (2) Document be                                          |                               |                                    |                                 |                                                                                        |                |            |  |
|                                   | complaint and the                                                           |                               |                                    |                                 |                                                                                        |                |            |  |
|                                   | complaint.                                                                  |                               |                                    |                                 |                                                                                        |                |            |  |
|                                   |                                                                             |                               | N0514                              |                                 | N0514 - Heaven Sent has                                                                |                | 02/08/2012 |  |
|                                   | Based on clinical                                                           |                               |                                    | conducted an investigation into |                                                                                        |                |            |  |
|                                   | review and interv                                                           | view, the agency failed to    |                                    |                                 | the matters cited in this deficiency. Further, we have fully                           |                |            |  |
|                                   | ensure all compl                                                            | aints regarding a lack of     |                                    |                                 | documented in our complaint I                                                          |                |            |  |
|                                   | respect for patien                                                          | nt's property were            |                                    |                                 | and cooperated with state offic                                                        |                |            |  |
|                                   | investigated in 1                                                           | (#7) of 3 clinical records    |                                    |                                 | to ensure a proper resolution is                                                       | S              |            |  |
|                                   | reviewed with th                                                            | e potential to affect all of  |                                    |                                 | found for the patient Heaven<br>Sent will ensure all complaints                        | or             |            |  |
|                                   | the patients serve                                                          |                               |                                    | information obtained by staff o |                                                                                        |                |            |  |
|                                   | 1                                                                           |                               |                                    | management is documented a      |                                                                                        |                |            |  |
|                                   | Findings include                                                            |                               |                                    | investigated Heaven Sent wil    |                                                                                        |                |            |  |
|                                   | C                                                                           |                               |                                    |                                 | design and document a suitab                                                           | le             |            |  |
|                                   | 1. On 1/27/12 at                                                            | t 11:15 AM, the               |                                    |                                 | action plan, based on the<br>information gathered during th                            | e              |            |  |
|                                   |                                                                             | irector of nursing (ADM       |                                    |                                 | investigation Heaven Sent w                                                            |                |            |  |
|                                   |                                                                             | d the agency had no           |                                    | (                               | contact the proper state officia                                                       |                |            |  |
|                                   | · · · · · · · · · · · · · · · · · · ·                                       | ot for one which she          |                                    |                                 | one of our employees is                                                                | 4              |            |  |
|                                   |                                                                             | t documented and was          |                                    |                                 | specifically named in a compla<br>- Heaven Sent will maintain                          | airīt.         |            |  |
|                                   |                                                                             | She stated, "I am sure it     |                                    |                                 | on-going compliance by                                                                 |                |            |  |
|                                   | _                                                                           | ne] since I discharged        |                                    |                                 | conducting complaint log audit                                                         | ts             |            |  |
|                                   |                                                                             | cated the power of            |                                    |                                 | every quarter and conducting                                                           |                |            |  |
|                                   |                                                                             | for patient # 7 called the    |                                    |                                 | annual client satisfaction surve<br>The Administrator will be                          | еу             |            |  |
|                                   |                                                                             | nately December 19,           |                                    |                                 | responsible for correction and                                                         |                |            |  |
|                                   |                                                                             | -                             |                                    |                                 | maintaining compliance.                                                                |                |            |  |
| 2011, and requested and named two |                                                                             |                               | 1                                  | <b>~</b> 1                      |                                                                                        |                |            |  |

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| AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   15K076 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CO  A. BUILDING  B. WING | 00                                                                                                                     | COMPLETED 01/27/2012 |
|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------------------------------------------------------------------------|----------------------|
|                                                          | PROVIDER OR SUPPLIER I SENT HOME HEALTH CARE LLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 211 S A                                | ADDRESS, CITY, STATE, ZIP CODE<br>ANDERSON ST<br>DD, IN 46036                                                          |                      |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | (X5) COMPLETION DATE |
|                                                          | persons, that were rendering care, no longer be sent to the patient's home and did not indicate why. The staff members named were employee C and another person that was not found on the personnel roster.  2. On 1/27/12 at 1:25 PM, the ADM /                                                                                                                                                                                                                                                                                                                                                    |                                        |                                                                                                                        |                      |
|                                                          | DON indicated employee C informed her the patient's POA "had accused the aides of stealing" money and possessions from the patient. She indicated that since the agency was not staffing the patient 24 hours a day, they could not be responsible. She further indicated this agency did not have any aides in the home and the person named and employee C were working for another home health agency in which the ADM / DON also works. The ADM / DON indicated she did not have any documentation to evidence the accusation or complaint had been acknowledged or investigated by the agency. |                                        |                                                                                                                        |                      |
|                                                          | 3. Clinical record #7, start of care 11/1/11, included a plan of care for the certification period 11/1/11 through 12/29/11 with orders for a skilled nurse once a month and for a home health aide 13 hours a night as a sitter, 7 days a week. The clinical record evidenced that only employee L, a registered nurse, provided the sitter services from this agency from 7                                                                                                                                                                                                                       |                                        |                                                                                                                        |                      |

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|                          | IT OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                           | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K076                          | (X2) MULTIPLE CC  A. BUILDING  B. WING | 00                                                                                           | COM       | e survey<br>pleted<br>17/2012 |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------|-----------|-------------------------------|
|                          | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                   | STREET A<br>211 S A                    | ADDRESS, CITY, STATE, ZIP<br>ANDERSON ST<br>DD, IN 46036                                     | CODE      |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION :<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE    |
|                          | 11/1/11 through record failed to e investigation was employee C brou attention of the a nursing.  4. The undated p Policy" states, "I during a home via asked to docume resolution in the problem cannot be patient's satisfact then a formal gri initiated Age to document cominclude the date of the individual regnature of the conthe resolution daresponse Coaddressed within director of nursir investigation and designee within a designee within a investigation and | 72 hours The ng will conduct an I respond to the patient or                       |                                        |                                                                                              |           |                               |

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