STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ONSTRUCTION 00	(X3) DATE S COMPLI	
			A. BUI B. WIN	LDING IG		01/27/2	
NAME OF I	PROVIDER OR SUPPLIER		D. WIL	_	ADDRESS, CITY, STATE, ZIP CODE		
	I SENT HOME HEA				ANDERSON ST		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	DD, IN 46036		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	\bot	TAG	DEFICIENCY)	.,,	DATE
G0000							
l	This was a rev	risit for a federal	G00	000	N0000 - Heaven Sent Home	1	İ
	Home Health	initial certification			Health Care LLC takes regula compliance very seriously. Th	-	
	survey conduc	cted on December 9,			plan of correction is to serve as		
	12, and 13, 20	11, that resulted in an			our credible allegation of compliance.		
	extended surv	ey.			compliance.		
	Survey Date:	January 27, 2012					
	Facility #: 012612						
	Madigaid Van	don II. Application					
	Medicald Ven	dor #: Application					
	Survevor: Bri	dget Boston, RN,					
	PHNS						
	During this surve	ey, one condition and					
		level deficiencies were					
		andard level deficiency					
	deficiency was c	one new standard level					
	actioners was c						
	Heaven Sent H	Home Health Care					
	LLC. is preclu	ided from providing					
	its own trainin	g and/or competency					
	evaluation pro	gram for a period of					
	, , -	beginning December					
		ecember 13, 2013,					
	_	ut of compliance					
	with the Cond	itions of Participation					

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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING	00		E SURVEY PLETED
			B. WING		- 01/2	7/2012
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 211 S ANDERSON ST ELWOOD, IN 46036			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	42 CFR 484.3	86: Home Health Aide				
	Services.					
		byce Elder, MSN, BSN, RN 2, 2012				

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Event ID: MM5E12

Facility ID: 012612

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
B. WING	01/27/2012
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 211 S ANDERSON ST	
HEAVEN SENT HOME HEALTH CARE LLC ELWOOD, IN 46036	<u> </u>
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION) TAG REGULATORY OR USC IDENTIFYING INFORMATION) TAG REGULATORY OR USC IDENTIFYING INFORMATION)	
THE REGULATOR OF THE INTERNATION INC.	DATE
G0107 The HHA must investigate complaints made by a patient or the patient's family or	
guardian regarding treatment or care that is	
(or fails to be) furnished, or regarding the	
lack of respect for the patient's property by	
anyone furnishing services on behalf of the	
HHA, and must document both the existence	
of the complaint and the resolution of the complaint.	
G0107 - Heaven Sent has	02/08/2012
Based on clinical record and policy conducted an investigation into	
the matters cited in this	
deficiency. Further, we have it	
to an arm a property with	
found for the patient - Heaven	
reviewed with the potential to affect all of Sent will ensure all complaints	
the patients served by the agency. information obtained by staff o	
management is documented a investigated Heaven Sent wil	
Findings include: Investigated Heaven Sent will design and document a suitab	
action plan, based on the	
1. On 1/27/12 at 11:15 AM, the information gathered during th	
administrator / director of nursing (ADM investigation Heaven Sent w	
/ DON) indicated the agency had no contact the proper state official one of our employees is	ils if
complaints except for one which she specifically named in a complaints	aint.
indicated was not documented and was - Heaven Sent will maintain	
not investigated. She stated, "I am sure it on-going compliance by	
was [patient name] since I discharged conducting complaint log audit	
them." She indicated the power of every quarter and conducting a annual client satisfaction surve	
attorney (POA) for patient # 7 called the The Administrator will be	зу
agency, approximately December 19, responsible for correction and	
2011, and requested and named two maintaining compliance.	
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	

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Event ID: MM5E12

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPI 01/27	ETED	
			B. WIN		DDDDGG GUTY GTATE TID GODE	01/27	2012
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE NDERSON ST		
HEAVEN	SENT HOME HEA	LTH CARE LLC			DD, IN 46036		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	personnel roster.						
	2. On 1/27/12 at DON indicated ethe patient's POA of stealing" mone the patient. She agency was not shours a day, they responsible. She agency did not he and the person nawere working for agency in which works. The ADM did not have any evidence the acceptance of the acceptance of the agency. 3. Clinical recording to the agency. 3. Clinical recording the acceptance of	e 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 d#7, start of care d a plan of care for the od 11/1/11 through ders for a skilled nurse d for a home health aide as a sitter, 7 days a week. In evidenced that only gistered nurse, provided as from this agency from 7 arough 8 AM daily from 12/27/11. The clinical evidence any complaint or as conducted when					
	Chiployee C 010t	ight the issue to the					

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Facility ID: 012612

If continuation sheet

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING 00 B. WING			COMPLETED 01/27/2012	
	PROVIDER OR SUPPLIER SENT HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 211 S ANDERSON ST ELWOOD, IN 46036					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION 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."						

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Event ID: MM5E12

Facility ID: 012612

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION			ONSTRUCTION	(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
			B. WIN			01/27/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ANDERSON ST		
ΗΕΔ\/ΕΝ	SENT HOME HEAD	LTH CARELLC			DD, IN 46036		
						-	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)		DATE
G0246		luation are reported to and					
	operation of the ag	se responsible for the					
l		strative document review	G02	1016	 G0246 - Heaven Sent will ado	nta I	02/08/2012
			1 002	40	process and patient oriented	pr u	02/06/2012
		e agency failed to ensure			Quality Assurance and		
		ce for an ongoing			Improvement plan Heaven		
		ntified issues and issues			Sent will conduct quarterly QA		
	-	by those responsible for			meetings to discuss data trend	ls	
	the operation of t	the agency for 1 of 1			and corrective action results Heaven Sent will form a Qualit	,	
	agency with the p	potential to effect all 12			Improvement Committee to	y	
	patients served by	y the agency.			include a member from each		
		-			discipline providing services		
	The findings incl	ude·			Heaven Sents' Board of Direct		
	The initings include.			will meet and adopt/approve th			
	1 Administrativ	e documents failed to			process and appoint the position		
					of Quality Coordinator Heav Sent will document all root cau		
	_	ncy prioritized the			data and corrective actions for		
	_	identified problems and			review by the Quality Committee		
	addressed how m				and quarterly review by the PA		
	effectiveness of t	the program would be			The Administrator will be		
	accomplished and	d documented.			responsible for implementation		
					and on-going supervision of th	is	
	2. On January 27	7, 2012, at 4:40 PM,			process.		
		cated the agency did not					
	1 2	g minutes that identified a					
		nent program or an					
		regarding the agency's					
		e program. There was not					
		place that objectively					
	and systematicall	ly monitored and					
	evaluated the qua	ality and appropriateness					
	of patient care, re	esolved identified					
	problems, and im	proved patient care.					
		•					
	3 The agency do	ocument titled "Board of					
	5. The agency de	Dould Of					

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Event ID: MM5E12

Facility ID: 012612

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
			B. WING		01/27/2012		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIEF	8		ANDERSON ST			
HEAVEN	SENT HOME HEA	LTH CARE LLC	ELWOOD, IN 46036				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	Directors Meetin	ng Minutes" dated 1/6/12					
	stated, "Added a	nd accepted QA					
	performance and	l improvement plan that is					
	OASIS based."	The meeting minutes					
	failed to identify	any written quality					
		agency evaluation plan.					
	improvement or	agency evaluation plans					
N0000			1	1	1 1		
՝ <u> </u>	This was a rev	visit for a state Home	N0000	N0000 - Heaven Sent Home			
				Health Care LLC takes regula	· .		
		licensure survey		compliance very seriously. Th			
	conducted on	December 9, 12, and		plan of correction is to serve a	as		
	13, 2011.			our credible allegation of compliance.			
	ŕ			compliance.			
	Survey Date:	January 27, 2012					
	Facility #: 01	2612					
	Madigaid Van	dor #: Application					
	Wiedicald Vell	doi #. Application					
	_	dget Boston, RN,					
	PHNS						
	During this surve	ey, seven deficiencies					
	_	two deficiencies were					
	'	new deficiencies were					
	cited.						
	Quality Review: Joy February	yce Elder, MSN, BSN, RN 2, 2012					

State Form Event ID: MM5E12 Facility ID: 012612 If continuation sheet Page 7 of 17

			ULTIPLE CC	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN			01/27	/2012
			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	PROVIDER OR SUPPLIER			211 S A	ANDERSON ST		
HEAVEN	I SENT HOME HEA	LTH CARE LLC		ELWOO	DD, IN 46036		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
N0456	responsible for an program designed (1) Objectively an and evaluate the cof patient care. (2) Resolve identi (3) Improve patien Based on admini and interview, tha plan was in platevaluation of idewere acted upon the operation of tagency with the patients served but The findings included and the compliance of the agency with the patients served but The findings included and the complished an	strative document review e agency failed to ensure ce for an ongoing ntified issues and issues by those responsible for the agency for 1 of 1 potential to effect all 12 y the agency. ude: de documents failed to ncy prioritized the identified problems and nonitoring of the the program would be d documented. 7, 2012, at 4:40 PM, cated the agency did not g minutes that identified a nent program or an regarding the agency's e program. There was not place that objectively	N04	156	N0456 - Heaven Sent will des and implement a plan to track and analyze issues with agen performance Heaven Sent document all issues related to agency performance, along w corrective actions taken to address identified issues Heaven Sents' Board of Direct will review and approve the pl for tracking agency performar and success of corrective actiplans Heaven Sent will maintain compliance by conducting a quarterly performance review, to be present for review is the Board Directors or the Professional Advisory Council The Administrator will be responsifor implementing and maintain this process.	cy will ith tors an ace on	02/08/2012
	and systematical	ly monitored and					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (22) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	TOP CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	- 01/27	
		B. WING	DDDDGG OWN OF THE CO		2012
NAME OF	PROVIDER OR SUPPLIER		.DDRESS, CITY, STATE, ZIP CO NDERSON ST	DDE	
HEAVE	N SENT HOME HEALTH CARE LLC		DD, IN 46036		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	,		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FU		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO	OULD BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATI	ION) TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)	PPROPRIATE	DATE
	of patient care, resolved identified				
	problems, and improved patient care.				
	2. The economic decomment titled "Decomb	£			
	3. The agency document titled "Board or Directors Meeting Minutes" dated 1/6/12				
	stated, "Added and accepted QA	2			
	performance and improvement plan that	is			
	OASIS based." The meeting minutes				
	failed to identify any written quality				
	improvement or agency evaluation plan.				
	1				I

State Form Event ID: MM5E12 Facility ID: 012612 If continuation sheet Page 9 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
			B. WING			01/27/	2012
			P. 11111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER				ANDERSON ST		
HEAVEN	SENT HOME HEA	LTH CARE LLC			DD, IN 46036		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPR		ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
N0460	records of the sup under subsection (1) Be kept currer (2) Include a copy (A) Limited crimir 16-27-2. (B) Nursing licens (C) Annual perfor (D) Documentation Performance evalus subsection must be to fifteen (15) more Based on personnel files in was obtained from the repository for criminformation as received as a comparison of the findings included as the reconstruction of the findings included as a contract 7/21/11, titled "Certificated 13, 2011. The end agency completed history from the funder her married name on agency completed history from the funder her married name in the reconstruction of the findings from the funder her married name on agency completed history from the funder her married name on the findings from the funder her married name on the findings from the funder her married name on the findings from the funder her married name on the findings from the funder her married name on the findings from the	y of the following: hal history pursuant to IC se. rmance evaluations. on of orientation to the job. uations required by this he performed every nine (9) of a ctive employment. hel file review and ency failed to ensure heluded a criminal history me the Indiana central minal history equired by IC 16-27-2 for of 2 files reviewed of ove a name change prior to	N04	60	N0460 - Heaven Sent will enstall criminal history checks will ran on all names applicable(IE Married Name, Maiden Name, Legally Changed Name) Heaven Sent has corrected be personnel files cited in this deficiency as of 2/8/2012 Heaven Sent will conduct natic criminal history checks through the Indiana state police, utilizin finger print based analysis (Where Applicable) as required by IC 16-27-2 Heaven Sent maintain on-going compliance conducting quarterly personne file audits, on not less than 10 of active employees The Administrator will be responsite for correction and on-going compliance.	be cith conal n ng d will by sl	02/08/2012

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	E SURVEY PLETED 7/2012
	PROVIDER OR SUPPLIER		211 S A	ADDRESS, CITY, STATE, ZIP C ANDERSON ST DD, IN 46036	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
		search under the en name and the name as he health registry.				
	date of hire 8/31/application for end in which the apprecently moved for Indiana and had name as a register file failed to evic history search that the Indiana centre.	L, a registered nurse, /11, evidenced an mployment dated 8/29/11 licant indicated she had from the state of Ohio to worked under a different ered nurse. The personnel lence a national criminal at included a search from al repository was both names listed by the				
	employee L indiana from Oh	7, 2012, at 4:15 PM, cated she had moved to io in December 2010 and her last name on				
	administrator / d indicated that em to all the patient' DON was busy v agency's patient	7, 2012, at 4:15 PM, the irector of nursing aployee L rendered care is because the ADM / with another home health load and indicated provided care to patient's				
		7, 2012, at 4:45 PM, icated the agency used a				

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STATEMEN	NT OF DEFICIENCIES	CIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			
			A. BUILDING B. WING		01/27/2012	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		ANDERSON ST		
HEAVEN	I SENT HOME HEA	NITH CAPELLO		OD, IN 46036		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	1	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	company called	Acxiom for the criminal				
	history searches	and did not have the				
	contract availab					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	ì ′	(3) DATE SURVEY			
		A. BUILDING	00		COMPLETED		
			B. WING		01/2	27/2012	
NAME OF	PROVIDER OR SUPPLIEF			T ADDRESS, CITY, STATE, ZIP COI	DE		
			S ANDERSON ST				
HEAVEN	N SENT HOME HEA	LTH CARE LLC	ELW	OOD, IN 46036			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORREC		(X5)	
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP		COMPLETION	
TAG	 	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
N0472		The home health agency plement, maintain, and					
	evaluate a quality						
		ovement program. The					
		ect the complexity of the					
		nization and services					
		ervices provided directly or nt). The home health					
		actions that result in					
	improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement						
		e objective measures.					
	Based on administrative document review and interview, the agency failed to ensure a plan was in place for an ongoing evaluation of identified issues and issues		N0472	N0472 - Heaven Sent w	ill adopt	02/08/2012	
				a process and patient or	ented	ant	
				Quality Assurance and	won Sont		
				Improvement plan Heaven Sent will conduct quarterly QA/QI			
	were acted upon	by those responsible for		meetings to discuss data trends and corrective action results Heaven Sent will form a Quality Improvement Committee to include a member from each discipline providing services Heaven Sents' Board of Directors will meet and adopt/approve this			
	-	the agency for 1 of 1					
	_	potential to effect all 12					
	patients served b	•					
	The findings inc	lude:					
	1. Administrativ	ve documents failed to		process and appoint the of Quality Coordinator			
	evidence the agency prioritized the resolution of any identified problems and addressed how monitoring of the effectiveness of the program would be accomplished and documented.			Sent will document all ro			
				data and corrective actio			
				review by the Quality Co			
				and quarterly review of the Administrator will be			
				responsible for implemen			
					and on-going supervision of this		
	2. On January 2	7, 2012, at 4:40 PM,		process.			
	1	icated the agency did not					
	have any meeting minutes that identified a quality improvement program or an						
		regarding the agency's					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLETED					
			B. WING 01/27/2012				
		_		ADDRESS, CITY, STATE, ZIP CODE	l		
NAME OF I	PROVIDER OR SUPPLIE	K		ANDERSON ST			
HEAVEN SENT HOME HEALTH CARE LLC			ELWOOD, IN 46036				
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
		ce program. There was not					
	_	place that objectively					
		lly monitored and					
	_	ality and appropriateness					
	_	resolved identified					
	problems, and in	mproved patient care.					
	3. The agency of	document titled "Board of					
		ng Minutes" dated 1/6/12					
		and accepted QA					
		d improvement plan that is					
	_	The meeting minutes					
		y any written quality					
		agency evaluation plan.					
	r						

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		ΓE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		B. WIN			01/27/	2012	
			1	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				211 S A	ANDERSON ST		
HEAVEN SENT HOME HEALTH CARE LLC				ELWOO	DD, IN 46036		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)		DATE
N0514	Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a						
	•	ent's family or legal					
	following:	arding either of the					
	•	care that is (or fails to be)					
	furnished.						
		espect for the patient's					
	property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the						
	complaint and the complaint.						
l	Based on clinical record and policy review and interview, the agency failed to		N05	1 14	N0514 - Heaven Sent has	h	02/08/2012
			1100		conducted an investigation into		02,00,2012
		aints regarding a lack of			the matters cited in this		
	•	nt's property were			deficiency. Further, we have fully documented in our complaint log and cooperated with state officials		
		#7) of 3 clinical records					
	_	e potential to affect all of			to ensure a proper resolution is		
	the patients serve	•			found for the patient Heaven		
	the patients serve	ed by the agency.			Sent will ensure all complaints		
	Findings include	lude:			information obtained by staff o management is documented a investigated Heaven Sent wi	ind ill	
	1. On 1/27/12 at	11:15 AM, the			design and document a suitab action plan, based on the	ie	
	administrator / di	irector of nursing (ADM			information gathered during th	e l	
	/ DON) indicated the agency had no complaints except for one which she indicated was not documented and was not investigated. She stated, "I am sure it was [patient name] since I discharged them." She indicated the power of				investigation Heaven Sent v	vill	
					contact the proper state officia	ls,	
					if one of our employees is	int	
					specifically named in a compla - Heaven Sent will maintain	ant.	
					on-going compliance by		
					conducting complaint log audit		
		For patient # 7 called the			every quarter and conducting	an	
	- '	imately December 19,			annual client satisfaction survey The Administrator will be responsible for correction and		
	2011, and requested and named two						
	persons, that were rendering care, no				maintaining compliance.		
	i persons, mai wer	c rendering care, no	I		ı '		

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PRINTED: 02/09/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING			COMPLETED 01/27/2012		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 211 S ANDERSON ST ELWOOD, IN 46036				
(X4) ID	AVEN SENT HOME HEALTH CARE LLC) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION DATE	
	longer be sent to did not indicate we named were employers on that was in personnel roster. 2. On 1/27/12 at DON indicated enthe patient's POA of stealing" mone the patient. She is agency was not shours a day, they responsible. She agency did not have and the person nawere working for agency in which tworks. The ADM did not have any evidence the accubeen acknowledge agency. 3. Clinical record 11/1/11, included certification period 12/29/11 with ord once a month and 13 hours a night at The clinical record employee L, a regular to the did not indicate the content of the clinical record employee L, a regular to did not indicate the clinical record employee L, a regular to did not indicate the clinical record employee L, a regular to did not indicate the clinical record employee L, a regular to did not indicate the clinical record employee L, a regular to did not indicate the clinical record employee L, a regular to did not indicate the clinical record employee L, a regular to did not indicate the clinical record employee L, a regular to did not indicate the clinical record employee L, a regular to did not indicate the content to did not have any evidence the accuracy to the content to did not have any evidence the accuracy to the content to did not have any evidence the accuracy to the content to did not have any evidence the accuracy to the content to did not have any evidence the accuracy to the content to did not have any evidence the accuracy to the content to did not have any evidence the accuracy to the content to did not have any evidence the accuracy to the content to did not have any evidence the accuracy to the content	the patient's home and why. The staff members loyee C and another ot found on the 1:25 PM, the ADM / mployee C informed her "had accused the aides by and possessions from andicated that since the taffing the patient 24 could not be further indicated this are any aides in the home amed and employee C another home health the ADM / DON also I / DON indicated she documentation to assation or complaint had and or investigated by the 1 #7, start of care a plan of care for the od 11/1/11 through ders for a skilled nurse as a sitter, 7 days a week. The devidenced that only gistered nurse, provided			CROSS-REFERENCED TO THE APPROPRIAT		
		from this agency from 7 rough 8 AM daily from					

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PRINTED: 02/09/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING			COMPLETED 01/27/2012			
NAME OF PROVIDER OR SUPPLIER HEAVEN SENT HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 211 S ANDERSON ST ELWOOD, IN 46036					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	11/1/11 through a record failed to e investigation was employee C brou attention of the admirsing. 4. The undated portion of the admirsing and home virus asked to document resolution in the problem cannot be patient's satisfact then a formal grid initiated Age to document comminclude the date of the individual regulature of the committee that the committee of the committe	vidence any complaint or conducted when ght the issue to the dministrator / director of olicy titled "Complaint a complaint is voiced sit the staff member is not the problem and the progress note. If the re resolved to the ion by the case manager evance process will be not will maintain a log plaints. The log will of the receipt, name of gistering the complaint, uplaint, action taken and re, time and type of mplaints will be 72 hours The g will conduct an respond to the patient or						

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