

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157644	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2013
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NAME OF PROVIDER OR SUPPLIER LOVING CARE AGENCY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 220 INSURANCE DR STE C FORT WAYNE, IN 46825
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N000000	<p>This was a home health State licensure survey</p> <p>Survey Dates: May 22-28, 2013</p> <p>Facility #: 012395</p> <p>Medicaid Vendor #: 201005960</p> <p>Clinical Records Reviewed: 5 Closed Records: 1 Active Records: 4 Home Visits: 3</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 5, 2013</p> <p>revised 6/19. je</p>	N000000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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N000512	<p>410 IAC 17-12-3(b)(4) Patient Rights Rule 12 Sec. 3(b)(4) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (4) The patient has the right to be as follows: (A) Free from verbal, physical, and psychological abuse. (B) Treated with dignity.</p> <p>Based on admission packet review, observation, clinical record review, policy review, and interview, the agency failed to ensure the patients were informed of the right to be free from abuse for 4 of 5 clinical records reviewed with the potential to effect all the agency's patients. (1, 3, 4, and 5)</p> <p>Findings include</p> <p>1. The agency's policy titled "Patient Bill of Rights," #C 007, revised 02/09 was in the admission packet and failed to include the patient has the right to be free from abuse.</p> <p>2. On 5/22/13 at 12:15 PM, employee A indicated the current Patient Bill of Rights document in the admission packet is not the most current. Employee A then provided a second Patient Bill of Rights document emailed from corporate 9/15/10</p>	N000512	The agency updated the patient bill of rights in 2010 to include the right to be free of abuse. All branch staff will be re-educated to the use of the current form. The current form will be added to the admission packet. In addition, 100% of current patients will be given the current pt bill of rights at their next recertification visit. An attestation form will be signed indicating receipt of such. Responsible Party: Director of Quality Management & Improvement, Regional Clinical Director, Area Director	06/30/2013			

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	<p>with changes and instructions to "begin using this updated form IMMEDIATELY." The second Patient Bill of Rights evidenced the right to be free from abuse. Employee A indicated she was not sure why this update did not take place.</p> <p>3. Home visit observation with patient #1 on 5/23/13 at 9:45 AM failed to evidence the parent had kept a copy of the admission packet. It was unable to be determined if patient / family received 2009 or 2010 copy of patient rights.</p> <p>4. Home visit observation with patient #3 on 5/28/13 at 10:00 AM failed to evidence the patient rights document was in the chart kept in the patient's home. The parent was not able to locate the admission packet for review. It was unable to be determined if patient / family received 2009 or 2010 copy of patient rights.</p> <p>5. Clinical records 4 and 5 were reviewed and included the parents received the patient's rights on the admission form but it was unable to be determined if they received the 2009 or 2010 copy.</p>			

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N000516	<p>410 IAC 17-12-3(d) Patient Rights Rule 12 Sec. 3(d) (d) The home health agency shall make available to the patient upon request, a written notice in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment, a listing of all individuals or other legal entities who have an ownership or control interest in the agency as defined in 42 CFR § 420.201, 42 CFR § 420.202, and 42 CFR § 420.206, in effect on July 1, 2005.</p> <p>Based on admission packet review, observation, clinical record review, policy review, and interview, the agency failed to ensure the patients were informed the right to request and receive disclosure of ownership for 5 of 5 clinical records reviewed with the potential to effect all the agency's patients. (1, 2, 3, 4, and 5)</p> <p>Findings include</p> <p>1. The agency's policy titled "Patient Bill of Rights," #C 007, rev 02/09 was in the admission packet and failed to include the patient has the right to receive disclosure of ownership if requested.</p> <p>2. On 5/22/13 at 12:15 PM, employee A indicated the current Patient Bill of Rights document in the admission packet is not the most current. Employee A then</p>	N000516	The agency will publish a list of all individuals or other legal entities who have an ownership or controlling interest in the agency. This list will be added to the admission packet currently utilized. The right to this list will be added to the current pt bill of rights. The current bill of rights will be added to the admission packet. In addition, 100% of current patients will be given the current pt bill of rights at their next recertification visit. An attestation form will be signed indicating receipt of such. Responsible Party: Director of Quality Management & Improvement; Regional Clinical Director; Area Director	06/30/2013	

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	<p>provided a second Patient Bill of Rights document emailed from corporate 9/15/10 with changes and instructions to "begin using this updated form IMMEDIATELY." The second Patient Bill of Rights failed to include the patient has the right to receive disclosure of ownership if requested. Employee A indicated she was not sure why this update did not take place.</p> <p>3. Home visit observation with patient #2 on 5/24/13 at 11:00 AM evidenced the admission packet Patient Rights document failed to evidence the right to disclosure of agency ownership if requested.</p> <p>4. Clinical records 1, 3, 4, and 5 included the parents received the patient's rights on the admission form, but it was unable to be determined if they received the 2009 or 2010 copy. However, neither copy contained the right to be informed of agency ownership if requested.</p>						

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N000522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, interview, and policy review the agency failed to ensure the physician ordered frequency and hours of Skilled Nurse (SN) visits were met for 5 of 5 clinical records reviewed with the potential to affect all the agency's patients. (1, 2, 3, 4, and 5)</p> <p>Findings include</p> <p>1. Clinical record #1, start of care (SOC) 7/9/12, contained a Plan of Care (POC) for the certification period 4/22-6/20/13 with orders for Skilled Nursing (SN) 5-8 hours per day, 4-6 days a week. On 5/10/13 a total of 10 hours SN care were provided, 2 hours over the ordered frequency for the day. The record failed to evidence any change orders for frequency were obtained.</p> <p>On 5/28/13 at 1:15 PM, employee C indicated what most likely happened was one of the parents was coming home late from work, so the nurse stayed until they got home.</p>	N000522	<p>The agency will complete a 100% review of all POCs to determine accuracy of orders re the frequency and duration of services. Frequency and durations will be rewritten and sent to MD for signature to accurately reflect the services being provided. Missed shifts will continue to be reported to the MD as needed. Branch staff will be educated about frequencies and staffing to MD orders. Responsible Party: Regional Clinical Director; Area Director</p>	06/30/2013			

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	<p>2. Clinical record #2, SOC 5/15/12, contained a POC for the certification period 3/11-5/9/13 with orders for SN 18-20 hours a day, 4-6 days a week. The record failed to evidence a total of 18 hours were provided on March 15, 17, 22, 24, 29, and 31; April 5, 7, 12, 14, 19, 21, 26, and 28; and May 3 with variations of 8-12 hours of care provided. A Missed Shift Report was completed on 5/3/13 for 2 hours missed due to parent canceled. The record failed to evidence any change orders for frequency were obtained.</p> <p>On 5/28/13 at 2:15 PM, employee C indicated Monday through Thursday is the 4 days a week the agency regularly fills so the agency is covered, but the parents don't need agency staff over 8 hours on Sundays.</p> <p>3. Clinical record #3, SOC 3/31/11, contained a POC for the certification period 3/9-5/7/13 with orders for SN 18-20 hours a day 4-5 days a week, with 60 hours per month respite at parent request. Physician orders for G-tube feedings state, "PediSure with Fiber: 4 times daily administer 160 mls (milliliters) via pump to run over 1 hour. Flush with 30-60 mls of water. ... Free water 360 ml total daily. 30 ml flush after each med."</p>			

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	<p>A. The record failed to evidence a total of 18 hours were provided on May 3 and 7. Missed Shift Reports were completed for 5/3/13 for 8 hours missed and 5/7 for 5 hours missed. Both stated due to "no nursing avail [available]." The record evidenced SN was also provided 8 hours a day every Saturday and 5-7 hours on all but two Sundays for the certification period. These hours total over the 60 hours of respite care for the certification period. Other Missed Shift Reports were completed for April 28, a Sunday, with reason noted as "Parent canceled, does not want nursing 12 p-6 p, offered to find alternate nurse for entire shift, [parent] declined."</p> <p>B. A Do Not Return Form was completed on 4/29/13 stating "[parent] states [employee J] is not a nurse for [patient]. [nurse] did not flush tubing after feeds. [parent] concerned about clinical skills." Discussion area states "Discussion regarding orders for SN. [nurse] directed to clarify orders with MD."</p> <p>C. Several Communication notes were observed in the clinical record documenting attempts to notify complainant regarding schedule changes. Many state "voicemail full;" some state "no answer." These notes are dated April</p>			

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	<p>24, 25, and 26 and May 6, 16, 17, and 23.</p> <p>D. On 5/22/13 at 3:05 PM, employee D, the scheduler, indicated they attempt to notify parents as soon as possible if a nurse is not available and attempt to fill open shifts right up to the last day. At 3:10 PM, employee D continued indicating the computer will block a nurse from an assignment once the agency has received a DNR form or notification from the parents, so the nurse does not come up as an option to call for coverage.</p> <p>4. Clinical record #4, SOC 9/25/12, contained a POC for the certification period 1/23-3/23/13 with orders for SN 14-18 hours a day 5-7 days a week. The patient was hospitalized 1/23 through 2/7 and 2/15 through 2/23/13. New orders were received on 2/6/13 for SN 6-9 hours a day 3-5 days a week. On 2/8/13 only 5 hours were provided, and a Missed Shift Report stated, "Sent nurse home early due to mom being home from work early." Other missed visits were noted for February 12, 14, and 27 due to "no nursing available." On 2/28, 5.75 hours were provided then parent sent nurse home. On 3/1/13 parent canceled due to "nurse running late." The 3/4 missed shift report states, "early dismissal." 3/5 missed shift states, "no nursing available." Orders were received on 3/6/13 to change</p>			

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	<p>hours to 8-10 hours a day 3-5 days a week. Other missed visit shift reports stating "no nursing available" for March 6, 13, 14, and 18.</p> <p>5. Clinical record #5, SOC 2/12/13, contained a POC for the certification period 2/12-4/12/13 with orders for SN 11-13 hours a day 4-6 days a week. The record failed to evidence a total of 11 hours of care were provided for 2/12-2/20/13. Missed Shift Report dated 2/13/13 stated reason as "no nursing avail." Missed Shift Report for 2/12, 15, and 16 stated, "Parents dismissed nurse early" and 2/14 was canceled by parents. New orders were obtained to change hours on 2/21/13 for 6-8 hours a day 5-7 days a week. The 2/23 and 2/ 28, 3/6, 3/7, and 3/9 dates were canceled by parents. Missed Shift Reports due to "nurse absence" were noted for 2/27, 3/6, 3/8, and 3/13.</p> <p>On 5/22/13 at 2:55 PM, employee A indicated the parent of this patient was not comfortable having the nurses at the house while they were home, so the parent frequently sent the nurses home early and took over care. Employee A also indicated the agency does not notify the physician of missed visits until the 60 day summary is sent for the following certification period with the</p>						

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	<p>recertification paperwork.</p> <p>6. The agency's policy titled "Physicians Orders," #3-10, revised 10/2009 states, "5. The physician will be notified of any need to change the orders for home care services ... Change Orders 1. Change orders will be obtained to modify physician orders or disciplines, services, medications that the agency is responsible to administer, frequency, duration or hours of care or services prior to implementing the change. ... Ranges 3. ... Open or missed shifts outside the frequency ordered by the physician require physician notification. This will be documented in the clinical record."</p> <p>7. The agency's policy titled "Scheduling," #3-2, revised 10/2009 states, "10. Unfilled hours are monitored and reported to the Clinical Manager and Branch Director each week, along with the reason the shift was not staffed and who was notified. Every effort is made to staff all shifts. 11. Missed shifts or hours outside the frequency ordered by the physician are to be reported to the physician. Notification will be documented in the record."</p>						