

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	<p>This visit was a home health agency state licensure survey.</p> <p>Survey Dates: January 2, 3, 4, 7, 2013.</p> <p>Facility ID#: 12050.</p> <p>Medicaid Vendor #: 200942280.</p> <p>Total unduplicated skilled admissions: 19.</p> <p>Record reviews: 7.</p> <p>Surveyor: Janet Brandt, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: right;">January 9, 2013</p>	N0000	Loving Care Agency acknowledges an survey was completed on 1/7/13.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
N0451	<p>410 IAC 17-12-1(c)(8) Home health agency administration/management Rule 12 Sec. 1(c)(8) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (8) Ensure that a qualified person is authorized in writing to act in the administrator's absence.</p> <p>Based on document review and interview, the administrator failed to ensure a qualified person was authorized in writing to act in the administrator's absence for 1 of 1 agency with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. In an interview with Employee C on 1-4-13 at 2:30 PM, Employee C indicated not being aware of a document authorizing any agency employee to act in the absence of the administrator.</p> <p>2. On 1-4-13 at 2:30 PM, Employee E indicated that, due to the fact that the administrator or alternate administrator was available at all times either in person or by telephone, the governing board felt that written documentation of a qualified person authorized to act in the administrator's absence was not necessary. Employee E indicated no</p>	N0451	<p>N451 <b>Action:</b> Agency will assure that each branch location has copies of Governing Body minutes approving both the Administrator and an appropriate Alternate. This information will be kept in a place that is readily available. If changes occur it is the responsibility of the Administrator to notify the Governing Body representative to approve those changes. <b>Responsible Party:</b> Corporate Clinical, Branch Director/Administrator  <b>Timeframe:</b> March 1, 2013  <b>Evaluation/Follow-up:</b> Presence of this information will be checked during ongoing Corporate Audits and also by the Regional VP during period visits to the branch.</p>	03/01/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation was available.  3. Review of the agency Governing Body meeting minutes failed to identify documentation authorizing a person to act in the absence of the administrator.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

N0478	<p>410 IAC 17-12-2(d) Q A and performance improvement Rule 12 Sec. 2(d) If personnel under contracts are used by the home health agency, there shall be a written contract between those personnel and the home health agency that specifies the following:</p> <ol style="list-style-type: none"> <li>(1) That patients are accepted for care only by the primary home health agency.</li> <li>(2) The services to be furnished.</li> <li>(3) The necessity to conform to all applicable home health agency policies including personnel qualifications.</li> <li>(4) The responsibility for participating in developing plans of care.</li> <li>(5) The manner in which services will be controlled, coordinated, and evaluated by the primary home health agency.</li> <li>(6) The procedures for submitting clinical notes, scheduling of visits, and conducting periodic patient evaluation.</li> <li>(7) The procedures for payment for services furnished under the contract.</li> </ol> <p>Based on interview and review of documents, the agency failed to ensure the contract for physical therapy services specified how contracted services were to be controlled, coordinated, or evaluated; the procedure for submitting clinical notes; the scheduling of visits; and conducting periodic patient evaluations for 1 of 1 contract reviewed with the potential to affect all patients of the agency receiving physical therapy services.</p> <p>Findings include:</p>	N0478	<p>N478</p> <p><b>Action:</b> The current Physical Therapy Contract will be reviewed and revised to include all required components. Upon revision the Agency will have the revised contract signed with the vendor. The revised contract will be utilized as necessary and appropriate going forward.</p> <p><b>Responsible Party:</b> Corporate Contracts, Branch Director/Administrator</p> <p><b>Timeframe:</b> March 1, 2013</p>	03/01/2013
-------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>1. Review of the contract with physical therapy services failed to evidence how the physical therapy services would be controlled, coordinated, or evaluated; the procedure for submitting clinical notes; the scheduling of visits; and conducting periodic patient evaluations.</p> <p>2. On 1-4-13 at 3:00 PM, Employee C indicated the contract with physical therapy services did not document how the physical therapy services would be controlled, coordinated, or evaluated; the procedure for submitting clinical notes; the scheduling of visits; and conducting periodic patient evaluations. Employee C indicated the contract was the current and only contract agreement the agency had for physical therapy services.</p> <p>3. On 1-4-13 at 3:00 PM, Employee E indicated that therapy services were not utilized very often and, when the services were utilized, a "Care Coordination with Outside Services" document was supposed to be completed between the agency and the contracted agency. That document could delineate and document responsibility for what the agency was responsible for and what the contracted agency was responsible for and whatever was supposed to have been on the contract could be added to that document.</p>		<p><b>Evaluation/Follow-up:</b> During ongoing Corporate audits any local sub-contracts will be reviewed to assure the correct format is being used. In addition the Area VP will periodically review these with the Branch Director.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
N0520	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.</p> <p>Based on clinical record, policy, and document review and interview, the agency failed to ensure appropriate staff were available to meet the patient's needs in the home in 4 of 7 records reviewed with the potential to affect all the agency's patients (#1, 2, 5, and 6.)</p> <p>Findings:</p> <p>1. Clinical record number #1, start of care (SOC) 5/27/11, the patient named in the complaint, identified the patient had a diagnosis of Central Alveolar Hypoventilation Syndrome. The plan of care established by the physician for the certification period 11-18-12 to 1-18-13 included orders for the skilled nurse (SN) to see the patient 8-13 hours per day, 5-7 days per week for 60 days. Per medical record documentation, though not on the plan of care, the skilled nurse was to attend school with the patient Monday through Friday.</p> <p>The record evidenced missed skilled nursing visits on 12/3/12 from 7 AM to 7</p>	N0520	<p>N520 Agency would like to respectfully disagree The Agency respectfully notes that in accordance with – 410 – IAC – 17 - 13 "Frequency of Visits - ..... may be expressed as a number range. The number of encounters must be at least one. All records reviewed reflected services provided within the range noted on the physician's plan of care. All records were reviewed and signed by a physician. All frequency for visits were met in accordance with the POC. <b>Action:</b> In the future, the Clinical Manager will re-educate all appropriate staff to assure that when there is a variance outside of the range noted on the plan of care, the ordering physician will be notified within the timeframe of that current cert period. This will be documented. In addition documentation will include reason for any unfilled visits including refusal by family. This information will also be shared as appropriate with the Case Manager to assist in care coordination and assuring patient's needs are met. The agency will incorporate into the</p>	03/01/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>PM, 12/7/12 from 7 AM to 7 PM, and 12/20/12 and 12/31/12 from 7 AM to 7 PM. The record evidenced a skilled nurse was not available to take the patient to school on these dates.</p> <p>2. Clinical Record #2, SOC 3-25-10, included a plan of care with orders for visits from a skilled nurse for 6-9 hours per day for 3-5 days per week for the certification period 11/9/12 to 1/7/13 and the skilled nurse was to attend school with the patient Monday through Friday.</p> <p>The record evidenced skilled nursing visits were missed on 11/26/12 and 11/29/12 for the certification period 11/9/12-1/7/13.</p> <p>3. Clinical record #5, SOC 6-21-11, included a plan of care for the certification period 12/12/ 12 - 2/9/13 with orders for skilled nursing visits to 8-13 hours per day 5-7 days a week for 60 days. The record evidenced missed visits on 12/26/12 and 12/28/12.</p> <p>4. Clinical record #6, SOC 10/11/10, included a plan of care with orders for skilled nursing visits 8-18 hours per day 4-7 days per week for 60 days for the certification period 11/1/12 -12/30/12. The record failed to evidence skilled nursing visits were made on 12/10/12 or</p>		<p>POC child's personal needs and agency nurse will provide when the nurse is present.</p> <p>Agency will continue to work with families to assure schedules are discussed and coverage is planned in accordance with the patient's needs.</p> <p><b>Responsible Party:</b> Clinical Manager or appropriate designee</p> <p><b>Timeframe:</b> March 1, 2013</p> <p><b>Evaluation/Follow-up:</b> A minimum of 10% of clinical records will be reviewed by the Clinical Manager or appropriate designee on a quarterly basis to assure continued compliance. This will also be reviewed during ongoing Corporate Clinical audits.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>12/18/12.</p> <p>5. Interview with Employee C on 1-3-13 at 12:30 PM, Employee C indicated the agency staffed pediatric cases including patients who were on ventilators and/or had tracheotomies and required intensive skilled nursing staffing. Employee C explained the Plan of Care listed the physician orders for frequency and duration of skilled nursing services for each patient. In addition, the Plan of Care listed under "Variances" the prior certification period dates that the frequency and duration of visits was not met by the agency. The listing of "variances" was the way the agency notified the physician the frequency and duration of visits per the Plan of Care had not been met as the physician or ordering practitioner signed the Plan of Care for each certification period. Per Employee C, the agency had within the last six (6) months instituted a practice of sending to each patient/primary care giver a calendar with skilled nursing scheduled visits and what nurse would be making those visits. The calendar was sent at least 1 week prior to the start of the new certification period. Per employee C, the patients who needed a skilled nurse to attend school Monday through Friday with them sent the agency a school calendar with the dates school was not in session marked</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>out on them so the agency could use that calendar as an assist to schedule staffing for the patient per patient/primary care giver need.</p> <p>6. In an interview with the primary care giver for patient #1 on 1-4-13 at 11:45 AM, the primary care giver indicated the agency nurse was supposed to take the patient to school Monday through Friday and the agency had not been able to consistently provide the needed staffing. Therefore, the patient has missed school and primary care giver has received complaints from the school due to the patient missing classes. The primary care giver further indicated the patient's Plan of Care frequency and duration may have been met as far as the days and hours of care provided by the agency, but sometimes the hours were not the hours school was in session and, therefore, the agency was not meeting the needs of the patient. The primary care giver indicated not meeting the needs of the patient for staffing had caused the primary care giver to make inconvenient alterations in personal schedules.</p> <p>7. On 1-4-13 at 11:45 AM, Employee G indicated that finding replacements for "call-offs" and planned absences by nurses was a problem for patient #1 and had prevented patient #1 from attending</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>school every other Monday for several months. Employee G indicated there was a lack of "back-up staff" trained to care for Patient #1. There was no one to fill the shift if a nurse "called off." Employee G indicated there was an agency "transition nurse" who was supposed to be able to fill in for "call offs," but the transition nurse was not available any of the shifts when there were "call offs" for patient #1 as far as going to school with patient #1 Monday through Friday.</p> <p>8. Complaint log included two (2) complaints received related to staff not being able to meet the patient's needs. Both complaints indicated skilled nurses were supposed to attend school Monday through Friday with the patient, but, due to no agency staffing, the patients had missed school on a routine basis.</p> <p>A. A complaint dated 12-18-12 was from patient #2's primary care giver who complained of "open" shifts affecting the care giver's work schedule; nurses were pulled from schedule and not replaced.</p> <p>B. A complaint dated 10-1-12 was from patient #1's waiver case manager related to primary care giver's complaint of lack of staffing for patient #1 to attend school Monday through Friday.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9. Policy 3-11, revised 09/2008, titled "Care Planning" states, "Care planning for each patient is individualized to address the patient's problems and needs, goals/outcomes, and specific care or services to be provided."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
N0522	<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:</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure skilled nurse visits had been provided as ordered by the physician on the written plan of care in 4 (#1, #2, #5, #6) of 7 records reviewed creating the potential to affect all of the agency's current patients that received skilled nursing services.</p> <p>The findings include:</p> <p>1. Clinical record number #1, start of care (SOC) 5/27/11, the patient named in the complaint, identified the patient had a diagnosis of Central Alveolar Hypoventilation Syndrome. The plan of care established by the physician for the certification period 11-18-12 to 1-18-13 included orders for the skilled nurse (SN) to see the patient 8-13 hours per day, 5-7 days per week for 60 days. Per medical record documentation, though not on the plan of care, the skilled nurse was to attend school with the patient Monday through Friday.</p>	N0522	<p>N522 <b>Action:</b> According to LCA policy 3-3 Admission; all pts are accepted pending assessment and determination if the pt needs fit the admission criteria and the agencies resources to meet the criteria. Agency will notify families when resources change or become unavailable. Agency will offer family other options for services and/or family will be contacted about level of care agency able to provide and such conversations/communications will be documented. <b>Responsible Party:</b> Clinical Manager or appropriate designee <b>Timeframe:</b> March 1, 2013 <b>Evaluation/Follow-up:</b> A minimum of 10% of clinical records will be reviewed by the Clinical Manager or appropriate designee on a quarterly basis to assure continued compliance. This will also be reviewed during ongoing Corporate Clinical audits.</p>	03/01/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The record evidenced missed skilled nursing visits on 12/3/12 from 7 AM to 7 PM, 12/7/12 from 7 AM to 7 PM, and 12/20/12 and 12/31/12 from 7 AM to 7 PM. The record evidenced a skilled nurse was not available to take the patient to school on these dates.</p> <p>2. Clinical Record #2, SOC 3-25-10, included a plan of care with orders for visits from a skilled nurse for 6-9 hours per day for 3-5 days per week for the certification period 11/9/12 to 1/7/13 and the skilled nurse was to attend school with the patient Monday through Friday.</p> <p>The record evidenced skilled nursing visits were missed on 11/26/12 and 11/29/12 for the certification period 11/9/12-1/7/13.</p> <p>3. Clinical record #5, SOC 6-21-11, included a plan of care for the certification period 12/12/ 12 - 2/9/13 with orders for skilled nursing visits to 8-13 hours per day 5-7 days a week for 60 days. The record evidenced missed visits on 12/26/12 and 12/28/12.</p> <p>4. Clinical record #6, SOC 10/11/10, included a plan of care with orders for skilled nursing visits 8-18 hours per day 4-7 days per week for 60 days for the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013	
NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>certification period 11/1/12 -12/30/12. The record failed to evidence skilled nursing visits were made on 12/10/12 or 12/18/12.</p> <p>5. Interview with Employee C on 1-3-13 at 12:30 PM, Employee C indicated the agency staffed pediatric cases including patients who were on ventilators and/or had tracheotomies and required intensive skilled nursing staffing. Employee C explained the Plan of Care listed the physician orders for frequency and duration of skilled nursing services for each patient. In addition, the Plan of Care listed under "Variances" the prior certification period dates that the frequency and duration of visits was not met by the agency. The listing of "variances" was the way the agency notified the physician the frequency and duration of visits per the Plan of Care had not been met as the physician or ordering practitioner signed the Plan of Care for each certification period. Per Employee C, the agency had within the last six (6) months instituted a practice of sending to each patient/primary care giver a calendar with skilled nursing scheduled visits and what nurse would be making those visits. The calendar was sent at least 1 week prior to the start of the new certification period. Per employee C, the patients who needed a skilled nurse to attend school</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013
NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Monday through Friday with them sent the agency a school calendar with the dates school was not in session marked out on them so the agency could use that calendar as an assist to schedule staffing for the patient per patient/primary care giver need.</p> <p>6. In an interview with the primary care giver for patient #1 on 1-4-13 at 11:45 AM, the primary care giver indicated the agency nurse was supposed to take the patient to school Monday through Friday and the agency had not been able to consistently provide the needed staffing. Therefore, the patient has missed school and primary care giver has received complaints from the school due to the patient missing classes. The primary care giver further indicated the patient's Plan of Care frequency and duration may have been met as far as the days and hours of care provided by the agency, but sometimes the hours were not the hours school was in session and, therefore, the agency was not meeting the needs of the patient. The primary care giver indicated not meeting the needs of the patient for staffing had caused the primary care giver to make inconvenient alterations in personal schedules.</p> <p>7. On 1-4-13 at 11:45 AM, Employee G indicated that finding replacements for</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/07/2013
NAME OF PROVIDER OR SUPPLIER  LOVING CARE AGENCY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>"call-offs" and planned absences by nurses was a problem for patient #1 and had prevented patient #1 from attending school every other Monday for several months. Employee G indicated there was a lack of "back-up staff" trained to care for Patient #1. There was no one to fill the shift if a nurse "called off." Employee G indicated there was an agency "transition nurse" who was supposed to be able to fill in for "call offs," but the transition nurse was not available any of the shifts when there were "call offs" for patient #1 as far as going to school with patient #1 Monday through Friday.</p> <p>8. Policy 3-10, revised 10/2009, "Physician Orders" states, "Ranges: Ranges are used as required by the care of the patient, in consideration of the family's ability to provide care, and as authorized by the payer. ... 3. Ranges are not to be used for the convenience of the agency, or where a nurse is not available to staff a shift."</p>				