

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER DINAMIC HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7826 CALUMET AVE STE C MUNSTER, IN 46321			
(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 was an off-site home health licensure investigation survey.</p> <p>Survey Date: August 20, 2012</p> <p>Facility Number: 012591</p> <p>Surveyor: Kelly Hemmelgarn RN</p> <p>During this offsite investigation, the agency was not in compliance with 410 IAC 17-12-1.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN August 20, 2012</p>	N0000					

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:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER DINAMIC HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7826 CALUMET AVE STE C MUNSTER, IN 46321			
(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			
N0450	<p>410 IAC 17-12-1(c)(7) Home health agency administration/management Rule 12 Sec. 1(c)(7) The administrator, who may also be the supervising physician or registered nurse required by subsection (d) of this rule, shall do the following: (7) Upon request, make available to the Commissioner or his or her designated agent all: (A) reports; (B) records; (C) minutes; (D) documentation; (E) information; and (F) files; required to determine compliance within seventy-two (72) hours of the request or, in the event the request is made in conjunction with a survey, by the time the surveyor exits the home health agency, whichever is sooner.</p> <p>Based on record review, the agency failed to ensure Indiana State Department of Health (ISDH) received evidence within the requested timeframe to support the qualifications of a nursing supervisor and alternate administrator.</p> <p>Findings include:</p> <p>1. Letter dated May 18, 2012, was mailed to Dinamic Health Care Inc. that stated, "This letter is to confirm receipt of correspondence and/or information regarding change(s) at your agency. Unfortunately, the Indiana State Department of Health cannot process your</p>	N0450	N 0450 On 09/28/2012 this deficiency was corrected with the following steps taken: The administrative staff of DINAMIC Health Care was educated and in-serviced on timely submission of required documentation per ISDH guidelines. All requested documents were sent in via fax. To prevent this deficiency from recurring in the future, the administrator will ensure that all responses and required supporting documentation are sent as required in a timely manner and will continue to provide on going education to staff in the form of inservicing.	09/28/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER DINAMIC HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7826 CALUMET AVE STE C MUNSTER, IN 46321			
(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>request unless the following documentation is received in our office. The Department is requesting information on the following staff: ... Alternate Director of Nursing ... Please submit the requested information to ensure compliance with Federal and State Rules and Regulations."</p> <p>2. Letter dated June 18, 2012, was mailed to Dinamic Health Care Inc. that stated, "RE: Second Notification ... This letter is to confirm receipt of correspondence and/or information regarding change(s) at your agency. Unfortunately, the Indiana State Department of Health cannot process your request unless the following documentation is received in our office. The Department is requesting information on the following staff: Alternate Director of Nursing ... Please submit the requested information to ensure compliance with Federal and State Rules and Regulations."</p> <p>3. On 7/12/12, Indiana State Department of Health received a document from Dinamic Health Care, LLC that stated, "Per our conversation today regarding the positions of Administrator and Alternate Director of Nursing, I will submit a change in management form for Administrator position for a new Administrator within by (sic) 7/31/12. Please allow 30 days for us to find a</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 08/20/2012	
NAME OF PROVIDER OR SUPPLIER DINAMIC HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7826 CALUMET AVE STE C MUNSTER, IN 46321			
(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>replacement for an alternate Director of Nursing that meets state requirements to fill this position."</p> <p>4. Letter dated August 2, 2012, was mailed to Dinamic Health Care Inc that stated, "RE: STAFF CHANGES -- 3RD NOTIFICATION ... This letter is to confirm receipt of correspondence and/or information regarding pending staff changes within your agency. As of the date of this letter the information that the Indiana State Department of Health has on record, in our database for your agency's administrative staff is shown below: Administrator Name: PENDING ... Alternate Nursing Director: PENDING. Failure to submit documents within fifteen (15) days of the date of this letter may result in further action pursuant to IC (Indiana Code) 16-27-1-12."</p> <p>5. As of August 20, 2012 (18 days from the letter mailed on 8/2/12), the ISDH had not received the requested information to process the position of administrator and alternate nursing supervisor.</p>						