

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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
N000000	<p>This visit was for a home health state licensure survey.</p> <p>Facility #: 11517</p> <p>Medicaid Vendor #: 200932770</p> <p>Dates of Survey: August 13, 14, 15, and 16, 2013.</p> <p>Unduplicated Admissions: 43.</p> <p>Surveyor: Janet Brandt, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>August 22, 2013</p>	N000000	This is not required	

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: 157602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2013
NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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	
N000504	<p>410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished.</p> <p>Based on clinical record review and staff interview, the agency failed to ensure the patient was advised of the frequency of visits and the disciplines providing services in 4 of 5 (#1-4) records reviewed with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. Medical record #1, Start of Care (SOC) 9-11-12, included a plan of care for the certification period from 7-8-13 to 9-5-13 with orders for skilled nursing, home health aide, and physical therapy services. The medical record did not contain documentation that the patient or POA (Power of Attorney) were informed of the frequency of treatment or the disciplines that would visit the patient.</p>	N000504	Deficiencies corrected for all clients cited in the survey on 8/16/2013 were corrected on 9/2/2013 using a chart audit review check list. The same chart audit reviews will be used to ensure all other clients have not been affected by the same deficiencies found on 8/16/2013. Maximum Home Health Care has had an in-service for all staff and will continue to have in-services in order to ensure deficiencies do not reoccur. In-service to discuss new form that was developed and adopted to policy and procedures book on frequency of visits in clients home and disciplines which will be provided by maximum home health care. Form will also be included in all new start of care packets; one copy will stay in patient's home folder and one copy will stay in patinets medical records chart in office. Nurse will instruct patient	09/02/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2013
NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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>2. Medical record #2, SOC 7-10-13, included a plan of care for the certification period 7-10-13-12 to 9-07-13 with orders for skilled nursing home health aide, physical therapy and occupational therapy. The medical record did not contain documentation the patient was informed of the frequency of treatment.</p> <p>3. Medical record #3, SOC 3-14-13, included a plan of care for the certification period 7-12-13 to 9-9-13 with orders for skilled nursing visits, home health aide visits, physical therapy and occupational therapy. The medical record did not contain documentation the patient was informed of the frequency of treatment or disciplines visiting.</p> <p>4. Medical record #4, SOC 6-21-13, included a plan of care for the certification period 6-21-13 to 8-19-13 with orders for skilled nursing visits and a physical therapy evaluation. The medical record did not contain documentation the patient was informed of the frequency of treatment or disciplines visiting.</p> <p>5. Employee A indicated on 8-15-13 at 11:30 AM that medical records for patient #1, #2, #3, #4 did not contain documentation the patient and/or POA was informed of the frequency of visits or</p>		<p>at Start of care and at each recertification that this form will be used for disciplines and frequencies of care. Maximum Home Health Care has developed a new tracking tool to ensure this deficiency does not reoccur in the future. The form will include patinets name, soc date/recert date, acknowledgement of frequency and discipline form and person who has checked chart and patient home folder. This will be monitored by director of nursing at start of care admission and recertification. Report & improvement plan if any deficiencies have occurred will be done by administrator on a quarterly basis</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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
	disciplines to visit.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2013	
NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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			
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 policy review, clinical record review, and interview, the agency failed to ensure visits and orders for acquisition of equipment were completed as ordered on the plan of care for 4 (#1, #2, #3, and #4) of 5 records reviewed with the potential to affect all of the agency's patients.</p> <p>The findings include:</p> <p>1. Clinical record #1, Start of Care (SOC) 9-11-12, included a plan of care for the certification period 7-8-13 to 9-5-13 with orders for skilled nurse to visit 3 times weekly for 7 weeks and PRN (as needed) and the physical therapist (PT) was to evaluate and treat the patient.</p> <p>A. The record failed to evidence 3 skilled nurse visits were made during weeks 2 and 5 or that a PT evaluation had been completed.</p> <p>B. In interview on 8-16-3 at 9:30 AM, Employee B stated, "We had documentation in the 'thinned' folder to cover most of the dates [of the missed</p>	N000522	<p>Tag N-0522 Deficiencies corrected for all clients cited in the survey on 8/16/2013 were corrected on 9/2/2013 using a chart audit review check list. The same chart audit reviews will be used to ensure all other clients have not been affected by the same deficiencies found on 8/16/2013. Maximum Home Health Care has had an in-service with all field staff for all disciplines on 8/19/2013 to check all charts and to develop a better strategy for compliance of policies and procedures of the agency. DON discussed in the in-service poc, orders, frequency of visits, missed visits, dme's/supplies and md notifications. Maximum Home Health has developed a new tracking tool named clinical record review; the form will include, name of patient, soc, frequency, poc, visits/missed visits, dme/supplies and physician orders. DON and Administrator will both be responsible for these new tracking tools. Maximum Home Health will have monthly in-services for all missed visits with all staff. We will conduct weekly reviews of charts to ensure missed visits forms have been filled out and patient was</p>	09/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2013	
NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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>visits]."</p> <p>2. Clinical record #2, SOC 7-10-13, had a plan of care for the period 7-10-13 to 9-7-13 for the skilled nurse visits to be done 2 times weekly for 9 weeks, the home health aide was to visit 2 times weekly, and the physical therapist and the occupational therapist (OT) were to evaluate the patient for treatment.</p> <p>A. The record failed to evidence 2 SN visits were made week 4.</p> <p>B. The OT documentation indicated that the agency RN, Employee B, suggested a "hold" on OT therapy until after the patient had visited the orthopedic surgeon. Employee B further confirmed with the OT that a platform walker had been ordered for the patient in order to comply with the non weight bearing (NWB) restriction ordered by the doctor for the patient.</p> <p>1.) On 7-31-13 the patient saw the orthopedic surgeon. No follow up was documented by the agency regarding the patient receiving OT services.</p> <p>2.) There was no documentation in the medical record that the patient received the platform attachment for the walker or the transport chair</p>		<p>scheduled to be seen within 48 hours of missed visit. New tracking tool, improvement plan have been created to ensure patients will be seen according to plan of care. This will be monitored by director weekly. Report & improvement plan if any deficiencies have occurred will be done by administrator on a quarterly basis.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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>3.) Interview on 8-15-13 at 10:00 AM, the patient indicated not having received a platform attachment for the walker. The patient indicated partial weight bearing (WB) status had been achieved on 8-12-13. Patient indicated having been bearing weight prior to that date because of not having the platform attachment for the walker.</p> <p>C. On 8-16-13 at 9:30 AM, Employee B indicated that OT had put the treatment on hold, but Employee B had not informed the primary doctor or the orthopedic surgeon or that the patient never received the platform attachment for the walker.</p> <p>D. The agency policy titled "Monitoring Patient's Response/Reporting to Physician, Policy No 2-029.1, revised October 2011 states, "Clinicians will establish and maintain ongoing communication with the physician to ensure safe and effective care to the patient." The policy stated the physician was to be contacted on the same day with "changes that have occurred regarding diagnoses, prognosis, or treatment (including procedures, medications, precautions, and limitations).</p> <p>3. Clinical record #3, SOC 3-14-13,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2013
NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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>included a POC for the certification period 7-12-13 to 9-9-13 with orders for a SN visit 1 times weekly for 9 weeks, a HHA (Home Health Aide) was to visit 2 times per week for 9 weeks, and PT and OT were to evaluate the patient for treatment. The record failed to evidence 2 HHA visits were made during week 1.</p> <p>4. Clinical record #4, SOC 6-21-13, included a POC for the certification period 6-21-13 to 8-19-13 with orders for the SN to visit 1 time weekly for 9 weeks. The record failed to evidence a SN visit was made weeks 5 and 7.</p> <p>Employee A, on 8-16-13 at 10:00 AM, indicated there was no other documentation available and the visit was not documented.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care included an accurate list of medications and treatments and the frequency of visits was designated on the POC for 3 (#1, 3, and 5) of 5 records reviewed with the potential to affect all of the agency patients.</p> <p>Findings include:</p>	N000524	<p>Tag N-0524 Deficiencies corrected for all clients cited in the survey on 8/16/2013 were corrected on 9/2/2013 using a chart audit review check list. The same chart audit reviews will be used to ensure all other clients have not been affected by the same deficiencies found on 8/16/2013. Maximum Home Health office staff has instituted a new form and is going to start following new office protocol after data entry is entered to assess for any deficiencies in data entry.</p>	09/02/2013
---------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2013	
NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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>1. Clinical record #1, Start of Care (SOC) 9-11-12, with a plan of care for the certification period 7-8-13 to 9-5-13 had orders for skilled nurse to visit 3 times weekly for 7 weeks and PRN (as needed). The POC stated the physical therapist (PT) was to evaluate and treat the patient. A physician order for home health aide visits 2 times daily was written on 7-8-13 but was not included on the POC. The POC failed to evidence a frequency or reason for the PRN visits.</p> <p>A. Medications listed on the "Medication Profile" but were not included on the POC included Prednisone 5 mg by mouth 1 time daily initiated 7-17-13 according to the medication profile, the Cipro 750 mg twice daily by mouth initiated on 7-17-13 according to the medication profile, Dyazide 37.5/25 mg by mouth daily initiated on 5-8-13 according to the Medication Profile. Tylenol #3 was listed as 2 tabs orally "as needed" on the medication profile instead of "every 4 hours as needed" for pain (initiated on 5-8-13). The Norvasc was listed on the POC did not have the supplemental note to "hold if systolic blood pressure 80 or less." The ZEA-sorb AT EX initiated according to the medication profile on 5-15-13 was not listed on the POC, nor was the Diclofenac 1% gel topical 3 times daily initiated on 5-15-13.</p>		<p>Staff will begin to check all plans of care, medication profiles, orders, oasis data entry, frequency, d/c plans and rehabilitation goals. DON and Administrator will check all charts before signing 485/poc and monitor monthly for any deficiencies that have occurred. Administrator will do a quarterly review and report.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2013	
NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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>B. On 8/14/13 at 9:30 AM, observation identified the patient had wound care and wound vac. The durable medical equipment and supply list on the POC did not include the wound vac and accompanying supplies.</p> <p>2. Clinical record #3, SOC 3-14-13, included a POC for the certification period 7-12-13 to 9-9-13. The POC included Diagnoses of Dementia without behavioral disturbance, spinal stenosis, hypertension. The physician identified the patient also had Peripheral Neuropathy and Osteoarthritis. These were not included on the POC.</p> <p>A. The "Medication Profile" was updated on 7-11-13 and 8-11-13 by Employee B included Lisinopril 20 mg by mouth every day was initiated on 7-11-13, Colace 100 mg 2 times per day orally (stool softener) was initiated 7-11-13, and Melatonin 10 mg oral (sleep supplement) was initiated 7-11-13. these medications were not listed on the plan of care.</p> <p>B. A physician visit note dated 7-17-13 listed Septra (antibiotic) 1 tablet by mouth every 12 hours initiated 6-7-13 and Ensure Plus (food supplement) initiated 4-15-13. However, neither was listed on the POC.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2013	
NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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>C. On 8-16-13 at 9:30 AM, Employee B stated, "The medications should have been updated, we have the same problem updating these POC as we did for [patient #1], the POC goes to India, the system makes all the POCs generic. Employee A used to update the POC but that can't be done with this system. Medications may be incorrect, DME may be incorrect."</p> <p>3. Clinical record #5, SOC 11-26-12, included a POC for the certification period 5-25-13 to 7-23-13 with orders for the SN to visit 2 times weekly, the HHA to visit 1 time during week 1 and 2 times weekly thereafter. The record included a physician order dated 5-24-13 that stated, "SN eval only". The physician order was not transferred to the POC for 5-25-13 to 7-23-13.</p> <p>4. Review of the agency policy, "Care Planning Process, Policy No. 2-018.1", revised October 2011, states the plan of care was to provide clinical direction to the clinicians providing care to agency patients. The POC was to be developed within 5 days of the start of care and updated at a minimum every 60 days. The POC was to include "pertinent diagnoses, mental status, types of services/equipment, frequency of visits, goals and interventions appropriate to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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
	each discipline, prognosis, rehabilitation potential, functional limitations, precautions, activities, nutritional requirements, food/drug allergies, medications, treatments, safety measures, instructions, discharge plan."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2013	
NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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			
N000527	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on clinical record review, staff interview, and agency policy review, the agency failed to ensure the doctor was informed of an increase in lower extremity edema (pt #2) and elevated blood pressure (pt # 3) in 2 of 5 medical records reviewed with the potential to affect all patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care (SOC) 7-10-13, failed to evidence the registered nurse contacted the physician with increased calf circumference measurements taken and recorded at the time of skilled nursing visits on 7-29-13 (21 cm.) and and 8-5-13(36 cm.)</p> <p>The POC the skilled nurse (SN) was to notify the physician of any significant changes in patient's condition. The SN was to perform vital signs each visit and focus assessment of critical indicators of patient's condition each visit as well.</p>	N000527	Tag- N-0527 Deficiencies corrected for all clients cited in the survey on 8/16/2013 were corrected on 9/2/2013 using a chart audit review check list. The same chart audit reviews will be used to ensure all other clients have not been affected by the same deficiencies found on 8/16/2013. Informed the nurses of their responsibility in calling the physician and reporting significant changes in an in-service with hand outs in vital sign parameters and discussed s&s's to report. Nurse will check all notes for abnormal vital signs and/or changes in status. Nurse will use nurse's weekly time log as a tracking tool and give to administrator for monthly review and report. Director of Nursing will be responsible for tracking all weekly time logs and will develop tracking tool for monthly review. DON will use a check list for any deficiencies and administrator will compile a monthly report to ensure deficiencies if any do not reoccur. Both administrator and DON will have monthly in-services to ensure no deficiencies reoccur and DON	09/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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>2. Clinical record #3, start of care 3-14-13, included a plan of care for 7-10-13 to 9-7-13 that identified the physician was to be notified if the patient's blood pressure was over 160 or under 90 Systolic and over 90 or under 50 Diastolic.</p> <p>On 7/15/13 the SN documented a blood pressure of 158/105. On 7/22/13 the SN documented a blood pressure of 154/97. On 8/5/13 the SN documented a blood pressure of 153/109. The record failed to evidence the physician was notified.</p> <p>3. The agency policy titled "Monitoring Patient's Response/Reporting to Physician, Policy No 2-029.1, revised October 2011 states: Clinicians will establish and maintain ongoing communication with the physician to ensure safe and effective care to the patient." The policy stated the physician was to be contacted on the same day with "changes that have occurred regarding diagnoses, prognosis, or treatment (including procedures, medications, precautions, and limitations).</p> <p>4. During interview on 8-16-13 at 11:00 AM, Employee A indicated the doctor should have been notified of any changes in the patient's condition and the agency failed to follow their own policies.</p>		and Administrator are both responsible for new tracking tool and improvement plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2013	
NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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			
N000546	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record review, staff interview, and agency policy review, the agency failed to ensure registered nurse informed the doctor of an increase in lower extremity edema (pt #2) and elevated blood pressure (pt # 3) in 2 of 5 medical records reviewed with the potential to affect all patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care (SOC) 7-10-13, failed to evidence the registered nurse contacted the physician with increased calf circumference measurements taken and recorded at the time of skilled nursing visits on 7-29-13 (21 cm.) and and 8-5-13(36 cm.)</p> <p>The POC the skilled nurse (SN) was to notify the physician of any significant changes in patient's condition. The SN</p>	N000546	<p>Tag- N-0527 Deficiencies corrected for all clients cited in the survey on 8/16/2013 were corrected on 9/2/2013 using a chart audit review check list. The same chart audit reviews will be used to ensure all other clients have not been affected by the same deficiencies found on 8/16/2013. Informed the nurses of their responsibility in calling the physician and reporting significant changes in an in-service with hand outs in vital sign parameters and discussed s&s's to report. Nurse will check all notes for abnormal vital signs and/or changes in status. Nurse will use nurse's weekly time log as a tracking tool and give to administrator for monthly review and report. DON and Administrator will be responsible for all tracking tools created for any changes in patients status. DON will follow new tracking tool to ensure every change in patient status has been documented and</p>	09/02/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2013	
NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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>was to perform vital signs each visit and focus assessment of critical indicators of patient's condition each visit as well.</p> <p>2. Clinical record #3, start of care 3-14-13, included a plan of care for 7-10-13 to 9-7-13 that identified the physician was to be notified if the patient's blood pressure was over 160 or under 90 Systolic and over 90 or under 50 Diastolic.</p> <p>On 7/15/13 the SN documented a blood pressure of 158/105. On 7/22/13 the SN documented a blood pressure of 154/97. On 8/5/13 the SN documented a blood pressure of 153/109. The record failed to evidence the physician was notified.</p> <p>3. The agency policy titled "Monitoring Patient's Response/Reporting to Physician, Policy No 2-029.1, revised October 2011 states: Clinicians will establish and maintain ongoing communication with the physician to ensure safe and effective care to the patient." The policy stated the physician was to be contacted on the same day with "changes that have occurred regarding diagnoses, prognosis, or treatment (including procedures, medications, precautions, and limitations).</p> <p>4. During interview on 8-16-13 at 11:00</p>		<p>physician has been contacted. DON will fill out form to include any changes by having visiting nurse fill out an MD notification and send it to the doctors office and have signature page for MD to sign. Form will also include when the MD was contacted by don or by visiting nurse about patient status change.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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
	AM, Employee A indicated the doctor should have been notified of any changes in the patient's condition and the agency failed to follow their own policies.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

N000608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record review and interview, the agency failed to ensure 2 (#1, #2) of 5 records reviewed had all documentation filed within 14 days of the visit with the potential to affect all patients of the agency.</p> <p>Findings</p> <p>1. Clinical record #1, Start of Care (SOC) 9-11-12, failed to evidence the following documents:</p> <p>A. A clinical document titled "Aide/Homemaker Care Plan" for patient</p>	N000608	<p>N-608 Deficiencies corrected for all clients cited in the survey on 8/16/2013 were corrected on 9/2/2013 using a chart audit review check list. The same chart audit reviews will be used to ensure all other clients have not been affected by the same deficiencies found on 8/16/2013.</p> <p>Maximum Home Health Care has had an in-service for all staff and will continue to have in-services in order to ensure deficiencies do not reoccur In-service to discuss new forms, clinical records and any deficiencies. Clinical records will be filed weekly by office staff, summaries and care plans will be checked for accuracy. Office</p>	09/02/2013
---------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2013
NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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>#1 with a date of 5/7/13 and signature of Employee B, Registered Nurse (RN).</p> <p>B. Clinical documents titled "Skilled Nursing Visit Missed Visit Note" with a date of 7/19/13 and 8-8-13 signed by Employee B.</p> <p>C. clinical document, physician order, dated 8-16-13, for extra thin duoderm application prior to wound vac application and a physician order dated 8-16-13 to discontinue packing a wound with gauze packing prior to wound vac application.</p> <p>2. Clinical record #2 , SOC 7-10-13, failed to evidence a physician order dated 8-16-13 for home physical therapy.</p> <p>3. When told the documents were missing, Employee A retrieved the documents. On 8/16/13 at 10:45 AM, Employee A, the administrator and director of nursing, indicated the above documents were not in the record because they had not been filed yet and should be in the record within 14 days.</p>		<p>staff, DON and Administrator will monitor clinical records on a weekly basis for timely less, accuracy, competition. DON will submit log to Administrator will create report on quarterly basis</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER MAXIMUM HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8220 CALUMET AVE 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