

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/08/2013
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NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 233 QUARTERMASTER COURT JEFFERSONVILLE, IN 47130
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G0000	<p>This visit was for a home health federal recertification survey. This was a partial extended survey.</p> <p>Survey dates: 1/2-4/2013, 1/7-8/2013</p> <p>Facility #007982</p> <p>Medicaid #200484160C</p> <p>Survey Team: Dawn Snider, RN, PHNS</p> <p>Census Service Type:</p> <p>Skilled Patients: 60 Home Health Aide Only Patients: 59 Personal Service Only Patients: 0 Total: 119</p> <p>Sample:</p> <p>RR w HV: 5 RR w/o HV: 5</p> <p>Total RR: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>January 17, 2013</p>	G0000	No Comment necessary	

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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G0121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on policy review, observation, and interview, the agency failed to ensure all employees followed proper infection control technique as required by agency policies for 2 of 5 (#3 and 6) home visit observations resulting in the potential to spread of infectious diseases to other patients and staff.</p> <p>Findings include:</p> <p>1. The policy dated 4/22/1 with a reference# HH-ICS-005 titled "HAND HYGIENE" states, "4.1. Hand decontamination with an alcohol-based hand rub: 4.1.1. Alcohol-based hand-rub which conforms to CDC Guideline for Hand Hygiene 4.1.4. Hand decontamination using an alcohol-based hand rub should be performed: 4.1.4.1. Before having direct contact with patients ... 4.1.4.3. After contact with a patient's intact skin (when taking a pulse, blood pressure, or lifting a patient)... 4.1.4.6. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient"</p>	G0121	<p>The Director of Clinical Services (DOCS) or Clinical Designee will provide education to all direct caregivers, including employees L and F regarding proper standards of hand hygiene. This in-service will include company policy requirements as stated in policy HH-ICS-005 as well as VNAA Clinical Guidelines for Hand Hygiene in the Health Care setting. Direct caregivers will be required to complete and pass a post test with 80% or greater to acknowledge understanding of hand hygiene requirements. The completion date for this education will be February 8 th , 2013. Employees L and F will receive education regarding proper hand hygiene from Clinical Supervisor by February 8 th , 2013 and logged into the system of record. The Director of Clinical Services will educate all Clinical Supervisors on policy HH-ICS-005 regarding hand hygiene as well as VNAA Clinical Guidelines for Hand Hygiene in the Health Care setting. The Clinical Supervisors will be required to complete and pass a post test with 80% or greater to acknowledge understanding of hand hygiene requirements. The</p>	02/08/2013

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	<p>2. During the home visit on 1/2/13 at 3:35 PM, the registered nurse, employee L, took vital signs on patient #3, including blood pressure, without washing his hands. The registered nurse indicated he had forgotten to wash his hands prior to patient contact.</p> <p>3. During the home visit on 1/4/13 at 3:45 PM, the licensed practical nurse (LPN) employee F, after performing tracheostomy care, removed her gloves and discarded her supplies for patient #6. The patient had mucous secretions oozing around the tracheostomy site. The LPN picked up the suction catheter to suction these secretions. The nurse did not wash her hands or don gloves prior to suctioning. The suction machine and equipment used for suctioning were kept on the carpeted floor next to the patient's hospital bed.</p> <p>4. On 1/3/13 at 4:20 PM, the director of business operations, who was also present during the home visit for patient #6, indicated he observed the LPN suction the patient without washing her hands or donning gloves, and the suction machine and equipment are located on the floor.</p>		<p>completion date for this education will is February 8, 2013. Furthermore to prevent this deficiency from recurring in the future, Director of Clinical Service or Clinical Supervisors will observe direct caregivers performing hand hygiene during the initial competency and during their annual competency evaluations. Clinical Supervisors will observe and monitor staff providing patient care for adherence to proper hand hygiene. This observation will take place during home supervisory visits when staff is present. The Clinical Supervisor will document the observation of staff on the Supervisory note, along with the effectiveness and any re-education provided.</p>		

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G0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on observation, clinical record review, policy review, and interview, the agency failed to ensure the care provided followed the plan of care orders for 2 of 8 active records reviewed (#2 and #7) with the potential to affect all the patients of the agency.</p> <p>The findings include:</p> <p>1. Clinical record #2, start of care 9/29/2011, included a plan of care for the certification period 11/13/12-1/11/13 with orders for "15. Safety Measures: Aspiration precautions: elevate patient's head at least 30 degrees during feeds and for at least 30 minutes after feeds."</p> <p>On 1/3/13 at 1:35 PM, during the home visit for patient #2, employee Q, the registered nurse, performed a gastrostomy tube feeding for the patient. The patient was kept flat on the floor during the feeding with his head on a small pillow. The nurse indicated this was the best technique to use so the feeding would infuse successfully. The nurse indicated</p>	G0158	<p>The DOCS will reeducate Clinical Supervisors by February 8, 2012 according to policy HH-CL-007.4 Home Health Certifications and Plans of Care. This reeducation will be documented by a sign in a sheet and agenda. By February 8, 2013, Clinical Supervisors will contact all staff in the homes of patient #2 and patient #7 to address the documentation regarding safety measures, aspiration precautions, and bathing routines as documented on the individualized plan of care in each patient's home. This reeducation will be documented in loggings for each staff member, including employee Q. The Clinical Supervisor for patient #2 went to the patient's home on 1/30/13 with new staff member to be assigned to case to investigate the feeding process. After confirming the physician's order and speaking with mother of patient, Clinical Supervisor and new staff member performed gtube feeding as recommended by the VNAA Procedure Manual: Patient was placed in semi-fowler's position for feeding and remained in that position for 30 minutes post feeding. Feeding was completed without residual or</p>	02/08/2013	

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	<p>she waits for about 10 minutes after the feeding, then changes the patient's incontinence pad with assistance from the patient's mother. Once these tasks were completed, the nurse sat the patient up and held the patient in her arms.</p> <p>2. Clinical record #7, start of care 4/22/11, included plans of care for the certification periods 10/13/12-12/11/12 and 12/12/12-2/9/13 with orders for the home health aide to provide total bed bath, bed bath, or shower 3 times weekly. The record failed to evidence the bath had been given on 12/1/12, 12/3/12, 12/5/12, 12/6/12, 12/9/12, 12/10/12, and 12/22/12.</p> <p>3. The policy dated 6/25/12 with a reference# HH-CL-007.4 titled "HOME HEALTH CERTIFICATION AND PLAN(S) OF CARE" states, "3.1. The Home Health Certification and Plan of Care (485) is the physician's order for home care services. 3.2. The Plan of Care will be individualized to include, but not limited to, all treatments, procedures, medications and services authorized to be provided by direct care staff(s)."</p>		<p>leaking. Patient's mother reeducated on this process. Physician's order will also reflect proper positioning during and post feeding. To ensure this deficiency will not occur in the future, all new staff added to the home will shadow with current appropriately trained staff member. Clinical Supervisors will all be educated by 2/8/2013 regarding VNAA procedure for gtube feedings, and nurses assigned to patient #2 will be educated on proper feeding/positioning and observed, if applicable, providing feedings during supervisory visits. These observations will be documented on the supervisory visit note. DOCS or Designee will audit 100% of Skilled Nursing to confirm that Skilled Nurses are providing treatment to correlate with the current physician order. Skilled Nursing notes are reviewed weekly as part of the Quality Assurance (QA) process. The Clinical Supervisor for patient #7 contacted staff in the home the day of the visit to discuss bathing three times per week. If bathing was not allowed by patient the Clinical Supervisor instructed staff on how to appropriately document the reason bathing was not performed.</p>		

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G0173	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions.</p> <p>Based on observation, clinical record and policy review, and interview, the agency failed to ensure the registered nurse revised the plan of care to include the specific information / care required to complete a tube feeding in 1 of 8 active clinical records reviewed (# 2) with the potential to affect all of the agency's patients.</p> <p>The findings include:</p> <p>1. Clinical record #2, start of care 9/29/2011, included a plan of care for the certification period 11/13/12-1/11/13 with orders for "15. Safety Measures: Aspiration precautions: elevate patient's head at least 30 degrees during feeds and for at least 30 minutes after feeds."</p> <p>On 1/3/13 at 1:35 PM, during the home visit for patient #2, employee Q, the registered nurse, performed a gastrostomy tube feeding for the patient. The patient was kept flat on the floor during the feeding with his head on a small pillow. The nurse indicated this was the best technique to use so the feeding would infuse successfully. The nurse indicated she waits for about 10 minutes after the</p>	G0173	<p>The DOCS will reeducate the Clinical Supervisors by February 8, 2013 during a clinical meeting. Education will review Maxim policy HH-CL-007.4 Home Health Certifications and Plans of Care as well as VNAA Nursing Procedure Manual. This reeducation will be documented by a sign in sheet and agenda. The Clinical Supervisor for patient #2 went to the patient's home on 1/30/13 with new staff member to be assigned to case to investigate the feeding process. After confirming the physician's order and speaking with mother of patient, Clinical Supervisor and new staff member performed gtube feeding as recommended by the VNAA Procedure Manual: Patient was placed in semi-fowler's position for feeding and remained in that position for 30 minutes post feeding. Feeding was completed without residual or leaking. Patient's mother reeducated on this process. Physician's order will also reflect proper positioning during and post feeding. To ensure this deficiency will not occur in the future, all new staff added to the home will shadow with current appropriately trained staff member. Clinical Supervisors will all be educated by 2/8/2013 regarding VNAA</p>	02/08/2013			

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	<p>feeding, then changes the patient's incontinence pad with assistance from the patient's mother. Once these tasks were completed, the nurse sat the patient up and held the patient in her arms.</p> <p>2. The policy dated 6/25/12 with a reference# HH-CL-007.4 titled "HOME HEALTH CERTIFICATION AND PLAN(S) OF CARE" states, "3.1. The Home Health Certification and Plan of Care (485) is the physician's order for home care services. 3.2. The Plan of Care will be individualized to include, but not limited to, all treatments, procedures, medications and services authorized to be provided by direct care staff(s)."</p> <p>3. The policy dated 10/15/12 with a reference # HH-CL-008.2 titled, "HOME HEALTH PLAN OF CARE" states, "3.2. Each patient receiving home health services will have an individualized plan developed by the Registered Nurse, ... which is consistent with the physician orders for care."</p>		<p>procedure for gtube feedings, and nurses assigned to patient #2 will be educated on proper feeding/positioning and observed, if applicable, providing feedings during supervisory visits. These observations will be documented on the supervisory visit note. DOCS or Designee will audit 100% of Skilled Nursing to confirm that Skilled Nurses are providing treatment to correlate with the current physician order. Skilled Nursing notes are reviewed weekly as part of the Quality Assurance (QA) process.</p>		

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G0224	<p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on clinical record and policy review, the agency failed to ensure the registered nurse completed accurate, clear instructions for the home health aide for 2 of 3 records reviewed of active patients (#5 and 7) receiving home health aide services with the potential to affect all the patients receiving aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record #5, start of care 3/16/12, included plans of care for the certification periods 9/11/12 - 11/10/12 and 11/11/12 - 1/9/13. The home health aide plan of care and updated by the registered nurse, employee P, on 11/9/12 included blood pressure every shift. The plans of care do not include orders for blood pressure every shift to be performed by the home health aide. Clinical record #7, start of care 4/22/11, included a plan of care for the certification period 12/12/12 to 2/9/13 	G0224	<p>By February 8, 2013, Clinical Supervisors will be re-educated by DOCS on the Home Health Aide Plan of Care Policy HH-CL-008.2. This re-education will be documented with a sign in sheet and agenda. Assigned Clinical Supervisor will contact MD for patient clinical record #5 to determine if a BP is needed every shift. If so, this will be added to the plan of care. All employees working in that home, including employee P, will be educated on the results of the conversation with the MD. A supplemental order will be sent for signature if changes are made. This will be completed by February 8, 2013. Re-education will be done by assigned clinical supervisor and logged. Staff members in the home of clinical record #7 will be educated by assigned clinical supervisor regarding frequency of bath, and appropriate documentation stating why bath is not given. Clinical supervisor will provide this education and log for each staff member by 2-8-13. To ensure this deficiency does not recur in the future, a review of the</p>	02/08/2013			

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	<p>that included orders for the home health aide to complete a total bed bath, bed bath, or shower 3 times weekly. The aide plan of care signed by the registered nurse on 4/11/12 and updated every 60 days failed to evidence the frequency of the bath for the patient.</p> <p>3. The policy dated 10/15/12 with a reference # HH-CL-008.2 titled "HOME HEALTH PLAN OF CARE" states, "3.2 Each patient receiving home health services will have an individualized plan developed by the Registered Nurse, ... which is consistent with the physician orders for care."</p>		Aide Care Plan will occur at the time of recertification by the DOCS or clinical designee for 100% of patients receiving aide services to ensure that assigned Clinical Supervisor made all applicable updates to the Aide Care Plan.		

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G0244	<p>484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation consists of an overall policy and administrative review and a clinical record review.</p> <p>Based interview and review of documents and policy, the agency failed to ensure quarterly chart audits were conducted as part of the evaluation process for 1 of 1 agency with the potential to affect all 119 patients of the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of agency documents failed to evidence any medical record reviews had been completed in the 2nd and 3rd quarters of 2012 as part of the evaluation process. 2. On 1/7/2013 at 2:30 PM, the administrator / director of clinical services indicated no chart audits had been done for the 2nd and 3rd quarters of 2012. 3. The agency policy titled "ANNUAL PROGRAM EVALUATION" reference #: HH-SOP-LGA-006d effective date 1/23/12 states, "10 Medical Record Review 10.1 Record four quarters of Medical Record Review quarterly tabulation form and document where 	G0244	<p>The fourth quarter audit was completed per Quality Improvement Plan HH-QI-001. The DOCS, Director of Business Operations (DBO), and Accounts Manager (AM) met on 01/08/2013 to address the action plan on how to prevent this in the future. On 01/08/2013 the DOCS reeducated the entire internal staff on the QI process during our weekly office meeting. To ensure this does not occur again in the future, 10 records or 10% of the total census will be reviewed quarterly. Evidence and Trends will be tracked and kept in a Self Audit binder. Trends will be identified, prioritized, and tracked through focus QA. The 2013 first quarter audit has already been opened and is currently being worked.</p>	02/08/2013			

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	indicated in the graph. Document target performance threshold for each indicator where indicated on the graph."			

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G0250	<p>484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.</p> <p>Based interview and review of documents and policy, the agency failed to ensure quarterly chart audits were conducted as part of the evaluation process for 1 of 1 agency with the potential to affect all 119 patients of the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of agency documents failed to evidence any medical record reviews had been completed in the 2nd and 3rd quarters of 2012 as part of the evaluation process. 2. On 1/7/2013 at 2:30 PM, the administrator / director of clinical services indicated no chart audits had been done for the 2nd and 3rd quarters of 2012. 3. The agency policy titled "ANNUAL PROGRAM EVALUATION" reference #: HH-SOP-LGA-006d effective date 1/23/12 states, "10 Medical Record Review 10.1 Record four quarters of Medical Record Review quarterly 	G0250	The fourth quarter audit was completed per Quality Improvement Plan HH-QI-001. The DOCS, Director of Business Operations (DBO), and Accounts Manager (AM) met on 01/08/2013 to address the action plan on how to prevent this in the future. On 01/08/2013 the DOCS reeducated the entire internal staff on the QI process during our weekly office meeting. To ensure this does not occur again in the future, 10 records or 10% of the total census will be reviewed quarterly. Evidence and Trends will be tracked and kept in a Self Audit binder. Trends will be identified, prioritized, and tracked through focus QA. The 2013 first quarter audit has already been opened and is currently being worked.	02/08/2013			

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	tabulation form and document where indicated in the graph. Document target performance threshold for each indicator where indicated on the graph."				

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N0000	<p>This visit was for a state home health relicensure survey.</p> <p>Survey dates: 1/2-4/2013, 1/7-8/2013</p> <p>Facility #007982</p> <p>Medicaid #200484160C</p> <p>Survey Team: Dawn Snider, RN, PHNS</p> <p>Census Service Type:</p> <p>Skilled Patients: 60 Home Health Aide Only Patients: 59 Personal Service Only Patients: 0 Total: 119</p> <p>Sample:</p> <p>RR w HV: 5 RR w/o HV: 5</p> <p>Total RR: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 17, 2013</p>	N0000	No Comment necessary				

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N0456	<p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p> <p>Based interview and review of documents and policy, the agency failed to ensure quarterly chart audits were conducted as part of the evaluation process for 1 of 1 agency with the potential to affect all 119 patients of the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of agency documents failed to evidence any medical record reviews had been completed in the 2nd and 3rd quarters of 2012 as part of the evaluation process. On 1/7/2013 at 2:30 PM, the administrator / director of clinical services indicated no chart audits had been done for the 2nd and 3rd quarters of 2012. The agency policy titled "ANNUAL PROGRAM EVALUATION" reference #: HH-SOP-LGA-006d effective date 	N0456	<p>The fourth quarter audit was completed per Quality Improvement Plan HH-QI-001. The DOCS, Director of Business Operations (DBO), and Accounts Manager (AM) met on 01/08/2013 to address the action plan on how to prevent this in the future. On 01/08/2013 the DOCS reeducated the entire internal staff on the QI process during our weekly office meeting. To ensure this does not occur again in the future, 10 records or 10% of the total census will be reviewed quarterly. Evidence and Trends will be tracked and kept in a Self Audit binder. Trends will be identified, prioritized, and tracked through focus QA. The 2013 first quarter audit has already been opened and is currently being worked.</p>	02/08/2013	

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N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on policy review, observation, and interview, the agency failed to ensure all employees followed proper infection control technique as required by agency policies for 2 of 5 (#3 and 6) home visit observations resulting in the potential to spread of infectious diseases to other patients and staff.</p> <p>Findings include:</p> <p>1. The policy dated 4/22/1 with a reference# HH-ICS-005 titled "HAND HYGIENE" states, "4.1. Hand decontamination with an alcohol-based hand rub: 4.1.1. Alcohol-based hand-rub which conforms to CDC Guideline for Hand Hygiene 4.1.4. Hand decontamination using an alcohol-based hand rub should be performed: 4.1.4.1. Before having direct contact with patients ... 4.1.4.3. After contact with a patient's intact skin (when taking a pulse, blood pressure, or lifting a patient)... 4.1.4.6. After contact with inanimate objects (including medical equipment) in the</p>	N0470	<p>The Director of Clinical Services (DOCS) or Clinical Designee will provide education to all direct caregivers, including employees L and F regarding proper standards of hand hygiene. This in-service will include company policy requirements as stated in policy HH-ICS-005 as well as VNAA Clinical Guidelines for Hand Hygiene in the Health Care setting. Direct caregivers will be required to complete and pass a post test with 80% or greater to acknowledge understanding of hand hygiene requirements. The completion date for this education will be February 8 th , 2013. Employees L and F will receive education regarding proper hand hygiene from Clinical Supervisor by February 8 th , 2013 and logged into the system of record.</p> <p>The DOCS will educate all Clinical Supervisors on policy</p>	02/08/2013			

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	<p>immediate vicinity of the patient"</p> <p>2. During the home visit on 1/2/13 at 3:35 PM, the registered nurse, employee L, took vital signs on patient #3, including blood pressure, without washing his hands. The registered nurse indicated he had forgotten to wash his hands prior to patient contact.</p> <p>3. During the home visit on 1/4/13 at 3:45 PM, the licensed practical nurse (LPN) employee F, after performing tracheostomy care, removed her gloves and discarded her supplies for patient #6. The patient had mucous secretions oozing around the tracheostomy site. The LPN picked up the suction catheter to suction these secretions. The nurse did not wash her hands or don gloves prior to suctioning. The suction machine and equipment used for suctioning were kept on the carpeted floor next to the patient's hospital bed.</p> <p>4. On 1/3/13 at 4:20 PM, the director of business operations, who was also present during the home visit for patient #6, indicated he observed the LPN suction the patient without washing her hands or donning gloves, and the suction machine and equipment are located on the floor.</p>		<p>HH-ICS-005 regarding hand hygiene as well as VNAA Clinical Guidelines for Hand Hygiene in the Health Care setting. The Clinical Supervisors will be required to complete and pass a post test with 80% or greater to acknowledge understanding of hand hygiene requirements. The completion date for this education is February 8, 2013. Furthermore to prevent this deficiency from recurring in the future, DOCS or Clinical Supervisors will observe direct caregivers performing hand hygiene during the initial competency and during their annual competency evaluations.</p> <p>Clinical Supervisors will observe and monitor staff providing patient care for adherence to proper hand hygiene. This observation will take place during home supervisory visits when staff is present. The Clinical Supervisor will document the observation of staff on the Supervisory note, along with the effectiveness and any re-education provided.</p>		

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N0472	<p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>Based interview and review of documents and policy, the agency failed to ensure quarterly chart audits were conducted as part of the evaluation process for 1 of 1 agency with the potential to affect all 119 patients of the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of agency documents failed to evidence any medical record reviews had been completed in the 2nd and 3rd quarters of 2012 as part of the evaluation process. 2. On 1/7/2013 at 2:30 PM, the administrator / director of clinical services indicated no chart audits had been done for the 2nd and 3rd quarters of 2012. 	N0472	<p>The fourth quarter audit was completed per Quality Improvement Plan HH-QI-001. The DOCS, Director of Business Operations (DBO), and Accounts Manager (AM) met on 01/08/2013 to address the action plan on how to prevent this in the future. On 01/08/2013 the DOCS reeducated the entire internal staff on the QI process during our weekly office meeting. To ensure this does not occur again in the future, 10 records or 10% of the total census will be reviewed quarterly. Evidence and Trends will be tracked and kept in a Self Audit binder. Trends will be identified, prioritized, and tracked through focus QA. The 2013 first quarter audit</p>	02/08/2013	

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	3. The agency policy titled "ANNUAL PROGRAM EVALUATION" reference #: HH-SOP-LGA-006d effective date 1/23/12 states, "10 Medical Record Review 10.1 Record four quarters of Medical Record Review quarterly tabulation form and document where indicated in the graph. Document target performance threshold for each indicator where indicated on the graph."		has already been opened and is currently being worked.	

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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 observation, clinical record review, policy review, and interview, the agency failed to ensure the care provided followed the plan of care orders for 2 of 8 active records reviewed (#2 and #7) with the potential to affect all the patients of the agency.</p> <p>The findings include:</p> <p>1. Clinical record #2, start of care 9/29/2011, included a plan of care for the certification period 11/13/12-1/11/13 with orders for "15. Safety Measures: Aspiration precautions: elevate patient's head at least 30 degrees during feeds and for at least 30 minutes after feeds."</p> <p>On 1/3/13 at 1:35 PM, during the home visit for patient #2, employee Q, the registered nurse, performed a gastrostomy tube feeding for the patient. The patient was kept flat on the floor during the feeding with his head on a small pillow. The nurse indicated this was the best technique to use so the feeding would infuse successfully. The nurse indicated</p>	N0522	<p>The DOCS will reeducate Clinical Supervisors by February 8, 2012 according to policy HH-CL-007.4 Home Health Certifications and Plans of Care. This reeducation will be documented by a sign in a sheet and agenda. By February 8, 2013, Clinical Supervisors will contact all staff in the homes of patient #2 and patient #7 to address the documentation regarding safety measures, aspiration precautions, and bathing routines as documented on the individualized plan of care in each patient's home. This reeducation will be documented in loggings for each staff member, including employee Q. The Clinical Supervisor for patient #2 went to the patient's home on 1/30/13 with new staff member to be assigned to case to investigate the feeding process. After confirming the physician's order and speaking with mother of patient, Clinical Supervisor and new staff member performed gtube feeding as recommended by the VNAA Procedure Manual: Patient was placed in semi-fowler's position for feeding and remained in that position for 30 minutes post feeding. Feeding was completed</p>	02/08/2013	

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	<p>she waits for about 10 minutes after the feeding, then changes the patient's incontinence pad with assistance from the patient's mother. Once these tasks were completed, the nurse sat the patient up and held the patient in her arms.</p> <p>2. Clinical record #7, start of care 4/22/11, included plans of care for the certification periods 10/13/12-12/11/12 and 12/12/12-2/9/13 with orders for the home health aide to provide total bed bath, bed bath, or shower 3 times weekly. The record failed to evidence the bath had been given on 12/1/12, 12/3/12, 12/5/12, 12/6/12, 12/9/12, 12/10/12, and 12/22/12.</p> <p>3. The policy dated 6/25/12 with a reference# HH-CL-007.4 titled "HOME HEALTH CERTIFICATION AND PLAN(S) OF CARE" states, "3.1. The Home Health Certification and Plan of Care (485) is the physician's order for home care services. 3.2. The Plan of Care will be individualized to include, but not limited to, all treatments, procedures, medications and services authorized to be provided by direct care staff(s)."</p>		<p>without residual or leaking. Patient's mother reeducated on this process. Physician's order will also reflect proper positioning during and post feeding. To ensure this deficiency will not occur in the future, all new staff added to the home will shadow with current appropriately trained staff member. Clinical Supervisors will all be educated by 2/8/2013 regarding VNAA procedure for gtube feedings, and nurses assigned to patient #2 will be educated on proper feeding/positioning and observed, if applicable, providing feedings during supervisory visits. These observations will be documented on the supervisory visit note. DOCS or Designee will audit 100% of Skilled Nursing to confirm that Skilled Nurses are providing treatment to correlate with the current physician order. Skilled Nursing notes are reviewed weekly as part of the Quality Assurance (QA) process. The Clinical Supervisor for patient #7 contacted staff in the home the day of the visit to discuss bathing three times per week. If bathing was not allowed by patient the Clinical Supervisor instructed staff member Q on how to appropriately document the reason bathing was not performed.</p>		

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N0542	<p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on observation, clinical record and policy review, and interview, the agency failed to ensure the registered nurse revised the plan of care to include the specific information / care required to complete a tube feeding in 1 of 8 active clinical records reviewed (# 2) with the potential to affect all of the agency's patients.</p> <p>The findings include:</p> <p>1. Clinical record #2, start of care 9/29/2011, included a plan of care for the certification period 11/13/12-1/11/13 with orders for "15. Safety Measures: Aspiration precautions: elevate patient's head at least 30 degrees during feeds and for at least 30 minutes after feeds."</p> <p>On 1/3/13 at 1:35 PM, during the home visit for patient #2, employee Q, the registered nurse, performed a gastrostomy tube feeding for the patient. The patient was kept flat on the floor during the feeding with his head on a small pillow. The nurse indicated this was the best</p>	N0542	The DOCS will reeducate the Clinical Supervisors by February 8, 2013 during a clinical meeting. Education will review Maxim policy HH-CL-007.4 Home Health Certifications and Plans of Care as well as VNAA Nursing Procedure Manual. This reeducation will be documented by a sign in sheet and agenda. By February 8, 2013, Clinical Supervisors will contact all staff in the homes of patient #2 to address the documentation regarding safety measures, aspiration precautions, and bathing routines as documented on the individualized plan of care in each patients home. This reeducation will be documented in loggings for each staff member including employee Q. The Clinical Supervisor for patient #2 went to the patient's home on 1/30/13 with new staff member to be assigned to case to investigate the feeding process. After confirming the physician's order and speaking with mother of patient, Clinical Supervisor and new staff member performed gtube feeding as recommended by the VNAA Procedure Manual:	02/08/2013	

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	<p>technique to use so the feeding would infuse successfully. The nurse indicated she waits for about 10 minutes after the feeding, then changes the patient's incontinence pad with assistance from the patient's mother. Once these tasks were completed, the nurse sat the patient up and held the patient in her arms.</p> <p>2. The policy dated 6/25/12 with a reference# HH-CL-007.4 titled "HOME HEALTH CERTIFICATION AND PLAN(S) OF CARE" states, "3.1. The Home Health Certification and Plan of Care (485) is the physician's order for home care services. 3.2. The Plan of Care will be individualized to include, but not limited to, all treatments, procedures, medications and services authorized to be provided by direct care staff(s)."</p> <p>3. The policy dated 10/15/12 with a reference # HH-CL-008.2 titled, "HOME HEALTH PLAN OF CARE" states, "3.2. Each patient receiving home health services will have an individualized plan developed by the Registered Nurse, ... which is consistent with the physician orders for care."</p>		<p>Patient was placed in semi-fowler's position for feeding and remained in that position for 30 minutes post feeding. Feeding was completed without residual or leaking. Patient's mother reeducated on this process. Physician's order will also reflect proper positioning during and post feeding. To ensure this deficiency will not occur in the future, all new staff added to the home will shadow with current appropriately trained staff member. Clinical Supervisors will all be educated by 2/8/2013 regarding VNAA procedure for gtube feedings, and nurses assigned to patient #2 will be educated on proper feeding/positioning and observed, if applicable, providing feedings during supervisory visits. These observations will be documented on the supervisory visit note. DOCS or Designee will audit 100% of Skilled Nursing to confirm that Skilled Nurses are providing treatment to correlate with the current physician order. Skilled Nursing notes are reviewed weekly as part of the Quality Assurance (QA) process.</p>		

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N0550	<p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on clinical record and policy review, the agency failed to ensure the registered nurse completed accurate, clear instructions for the home health aide for 2 of 3 records reviewed of active patients (#5 and 7) receiving home health aide services with the potential to affect all the patients receiving aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record #5, start of care 3/16/12, included plans of care for the certification periods 9/11/12 - 11/10/12 and 11/11/12 - 1/9/13. The home health aide plan of care and updated by the registered nurse, employee P, on 11/9/12 included blood pressure every shift. The plans of care do not include orders for blood pressure every shift to be performed by the home health aide. Clinical record #7, start of care 4/22/11, included a plan of care for the certification period 12/12/12 to 2/9/13 	N0550	<p>By February 8, 2013, Clinical Supervisors will be re-educated by DOCS on the Home Health Aide Plan of Care Policy HH-CL-008.2. This re-education will be documented with a sign in sheet and agenda. Assigned Clinical Supervisor will contact MD for patient clinical record #5 to determine if a BP is needed every shift. If so, this will be added to the plan of care. All employees working in that home, including employee P, will be educated on the results of the conversation with the MD. A supplemental order will be sent for signature if changes are made. This will be completed by February 8, 2013. Re-education for all staff, including employee P, will be done by assigned clinical supervisor and logged. Staff members in the home of clinical record #7 will be educated by assigned clinical supervisor regarding frequency of bath, and appropriate documentation stating why bath is not given. Clinical supervisor will provide this education and log for each staff</p>	02/08/2013			

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	<p>that included orders for the home health aide to complete a total bed bath, bed bath, or shower 3 times weekly. The aide plan of care signed by the registered nurse on 4/11/12 and updated every 60 days failed to evidence the frequency of the bath for the patient.</p> <p>3. The policy dated 10/15/12 with a reference # HH-CL-008.2 titled "HOME HEALTH PLAN OF CARE" states, "3.2 Each patient receiving home health services will have an individualized plan developed by the Registered Nurse, ... which is consistent with the physician orders for care."</p>		<p>member by 2-8-13.</p> <p>To ensure this deficiency does not recur in the future, a review of the Aide Care Plan will occur at the time of recertification by the DOCS or clinical designee for 100% of patients receiving aide services to ensure that assigned Clinical Supervisor made all applicable updates to the Aide Care Plan.</p>		

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N0608	<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 the clinical record was current and documents were filed within 14 days in 8 of 8 records reviewed of active patients (#1, 2, 3, 4, 5, 6, 7, and 8) with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 4/21/11, included plans of care dated 10/12/12-12/10/12 and 12/11/12 -2/8/13 that evidenced the patient was receiving skilled nurse service 30-50 hours per</p>	N0608	By 2/8/2013, the DOCS will reeducate internal staff including the Clinical Supervisors on Medical Record Content and Requirements policy HH-CL-002. This reeducation will be documented with a sign in sheet and agenda. An action plan has been put into place by which the Administrative Assistant will file Medical Record documentation by close of business Wednesday each week. This will be monitored on a weekly basis at staff meetings as an agenda item. Calendar reminders are set and DBO/DOCS/AM will all receive notice when filing is complete. Filing is currently up to date with this new process in place.	02/08/2013			

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	<p>week for 9 weeks. The clinical record failed to evidence skilled nurse visit notes after 12/22/12.</p> <p>2. Clinical record #2, start of care 9/20/11, included a plan of care dated 10/16/12-12/14/12 and 12/15/12-2/12/13 that evidenced the patient was receiving home health aide service 18-30 hours per week for 9 weeks. The clinical record failed to evidence home health aide visit notes after 12/21/12.</p> <p>3. Clinical record #3, start of care 9/11/08, included a plans of care dated 10/20/12-12/18/12 and 12/19/12-2/16/13 that evidenced the patient was receiving skilled nurse service 33-55 hours per week for 9 weeks. The clinical record failed to evidence skilled nurse visit notes after 12/21/12.</p> <p>4. Clinical record #4, start of care 8/17/12, included a plans of care dated 10/16/12-12/14/12 and 12/15/12-2/12/13 that evidenced the patient was receiving home health aide service 21-35 hours per week for 9 weeks. The clinical record failed to evidence home health aide visit notes after 12/21/12.</p> <p>5. Clinical record #5, start of care 3/16/12, included a plan of care dated 11/11/2012-1/9/2013 that evidenced the</p>						

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	<p>patient was receiving home health aide service 36-60 hours per week for 9 weeks. The clinical record failed to evidence home health aide visit notes after 12/15/12.</p> <p>6. Clinical record #6, start of care 9/22/10, included a plan of care dated 11/10/12-1/8/13 that evidenced the patient was receiving skilled nurse service 50-84 hours per week for 9 weeks. The clinical record failed to evidence skilled nurse visit notes after 12/14/12.</p> <p>7. Clinical record #7, start of care 4/22/12, included a plans of care dated 10/13/12-12/11/12 and 12/12/12-2/9/13 that evidenced the patient was receiving home health aide service 25-42 hours per week for 9 weeks. The clinical record failed to evidence home health aide visit notes after 12/23/12.</p> <p>8. Clinical record #8, start of care 7/11/2008, included a plan of care dated 12/17/12-2/14/13 that evidenced the patient was receiving skilled nurse service 26-44 hours per week for 9 weeks. The clinical record failed to evidence skilled nurse visit notes after 12/21/12.</p> <p>9. On 1/8/2013 at 2:45 PM, the administrator/director of clinical services and the director of business operations</p>				

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	indicated Maxim's policy was to file all clinical documents in the clinical record within 14 days of the visit.			