

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157591	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2015
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NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4646 W JEFFERSON BLVD STE 100 FORT WAYNE, IN 46804
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G000000	<p>This was a federal home health recertification survey. This was an extended survey. This survey was conducted concurrently with a complaint survey that resulted in an IJ. The IJ was removed at exit.</p> <p>Partial extended date: January 14, 2015. Extended survey date: January 15-23, 2015.</p> <p>Facility #: 003757</p> <p>Medicaid #: 200484160</p> <p>Survey Dates: January 14-23, 2015</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS\</p> <p>Census Service Type:</p> <p>Skilled: 33 Home Health Aide Only: 40 Personal Care Only: 0 Total: 73</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5</p>	G000000	<p>Bysubmitting this POC the agency does not admit the allegations in the surveyreport or that it violated any regulations. The agency is submitting thisPOC in response to its regulatory obligations and commitment to compliance. Theagency further reserves the right to contrast any alleged findings, conclusionsand deficiencies. The agency intends to request that this POC service asits Credible Allegation of Compliance.</p>	

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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	<p>Total: 10</p> <p>Maxim Healthcare Services Inc. is precluded from providing its own training and competency evaluation program for a period of 2 years beginning January 23, 2015, to January 23, 2017, for being found out of compliance with the Conditions of Participation 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision; 484.30 Skilled Nursing Services; and 484.36 Home Health Aide Services.</p> <p>An Immediate Jeopardy was identified on 1/16/15. The Administrator and Alternate Administrator were notified of the Immediate Jeopardy on 1/16/15 at 1:30 PM.</p> <p>An immediate jeopardy (IJ) was identified on 1/16/15 at 1:30 PM, with regard to failure to ensure proper Hoyer and/or lift competency testing with home health aides (HHAs) prior to assigning to patients with Hoyer, or other lifts, resulting in injury of a left humerus fracture to patient #8; failure to competency test HHAs with pseudo patients or live patients per employee interviews; and failure to document specific Hoyer/lift transfer skills for HHAs. Employees A and B were notified of the IJ on 1/16/15 at 1:30 PM.</p>						

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	<p>The IJ was removed on 1/23/15, but the agency remained out of compliance at condition level as the agency had only competency tested 31 of 31 current HHAs providing services to patients with Hoyer lifts/stander lifts. Continuation of HHA skills competency testing for the remaining HHAs needed to continue the following week with HHAs not currently assigned to lift patients. The agency provided documents for review by surveyor on 1/23/15 which evidenced the 31 HHAs assigned to Hoyer lift patients had received the competency updates in relation to the IJ. The agency evidenced the HHA skills competency forms were changed to include specific durable medical equipment skills being competency tested, included an area added for other equipment, and included a box to check if the skill was performed on a live or pseudo patient. Condition level remains at G212 as Maxim was still conducting competency testing for the remaining home health aides. An inservice was conducted with all the recruiters about complaints and was completed on 1/20/15. This was verified by inservice documentation.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p>			
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G000107	<p>February 4, 2015</p> <p>484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP</p> <p>The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on complaint log review, policy review, and interview, the agency failed to ensure all complaints or concerns regarding care were documented and investigated for 1 of 1 complaint log review, creating the potential to affect all the agency's patients. (# 8 and 10)</p> <p>Findings include</p>	G000107	<p>Response to G 107 Exercise of Rights and Respect forProperty</p> <p>The substantive issues raised by the Patients #8 and #10have been addressed. Employee D wassuspending pending investigation on 01-16-2015, based on the allegation oftheft from Patient #10. Patient #10'sservices have been consistently staffed since</p>	02/18/2015

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	<p>1. During home visit observation on 1/20/15 at 12:50 PM, patient #8 indicated their family member told agency employee H, several times, that employee C needed to be re-trained on the Hoyer lift but that never happened.</p> <p>2. The agency complaint log failed to evidence any complaints about home health aides (HHA) needing to be re-trained.</p> <p>3. During interview on 1/16/15 at 11:20 AM, employee H indicated these complaints/concerns go under worker loggings, but it is not saved anywhere.</p> <p>4. During interview on 1/16/15 at 1:50 PM, employee A, administrator, indicated they have not heard of any requests, complaints, or concerns of HHA need re-training.</p> <p>5. During interview on 1/16/15 at 1:10 PM, employee A indicated patient # 10 said okay for a home visit next week, but the patient was planning on also telling surveyor about employee D, a HHA who stole from the patient. Employee A indicated the police already investigated and that employee is in jail.</p> <p>A. The agency's complaint log failed</p>		<p>1-18-15. As further detailed under discussion of(G134/N446), all Aides, including employee C, have received updated competencyassessments for all patient transfer techniques. The grievance log will bereviewed to ensure that all documented grievances, including those frompatient's #8 and #10 have been investigated per Company policy. This review will be completed by the DOCS andAM/designee by 2/13/15. All internal office staff will be re-educated on the CompanyPolicies titled "Grievance and Complaints" and "Patient/Client Rights andResponsibilities". An office processwill be developed, based on the current Grievance Policy, in order to ensurethat all complaints or concerns regarding care are documented and investigated,as well as to avoid inconsistent/lack of response and follow up when the officeis notified of concerns with staff competency related to performancetasks/skills in the home setting as well as when a request is made by familymember, patient or caregiver for additional staff training on askill/task/DME. This process will includesteps to take when a call is received by non-clinical staff as well as stepsfor clinical designee to take when following up on the reported concern and/orrequest. All internal office staff will be educated onthe new process, including existing Company Grievance policy and Patient/ClientRights and</p>				

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	<p>to evidence a complaint about employee D having stolen anything from patient # 10. The only complaint evidenced about employee D was dated 10/22/14 and involved the employee eating patient # 8's food, and was resolved on 11/20/14.</p> <p>B. On 1/21/15 at 10:25 AM, surveyor called patient #10. Patient #10 indicated they did not cancel the visit, they just did not want employee K at the home visit also as they had things they wanted to tell the surveyor without the employee around for fear of retaliation. Patient # 10 indicated the weekend before Christmas, they did not have any help for 4 days straight and the following week they had 5 different aides, and the aides stole over \$10,000.00 worth of jewelry from them. Patient indicated some of the jewelry was located at a pawn shop. Patient indicated they had called the agency to ask for the phone number to Indiana State Department of Health (ISDH) because they wanted to file a complaint about being left without help for 4 days straight, and the agency told the patient to just call the compliance line for Maxim.</p> <p>C. Clinical record # 10 evidenced a communication note dated 12/18/14 between the patient's case manager at Real Services and the agency, and stated,</p>		<p>Responsibilities policy, by 2/18/15 by the DOCS/AM/designee. This education will be documented and maintained in the QI binder. Each internal staff member will sign an acknowledgement form to indicate receipt and understanding of the new process. Additionally, all employees are required to take the Company's Annual Compliance training which includes education specific to Patient Rights. Weekly, the DOCS and AM/designee will review the grievance log to ensure that all complaints and concerns have been documented and are being investigated per Company policy. This weekly review will be documented on a Grievance Trackers spreadsheet. This weekly review began 2/6/15 and will continue on-going.</p> <p>To ensure this alleged deficiency does not recur, the DOCS or designee will review the Grievance binder and Grievance Tracker spreadsheet during quarterly self-audits to ensure that all complaints or concerns, including all reports of concerns with staff competency when performing a task/skill or request for additional staff training on a skill/task/DME are addressed by clinical designee and all required follow up has been completed.</p> <p>The Accounts Manager/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is</p>	

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	<p>"Spoke with [name of case manager] with Real Services in regards to [patient's] staff. [case manager] stated that [patient] said they did not have staff for four weeks and [patient] would like to report an incident report to the state. I ran through the days that we had staff for [patient] since the HHA was pulled for legal concerns. [Case manager] said there is no need to write an incident report since [patient] has been staffed for the most part." This documentation was entered by employee J at 4:05 PM.</p> <p>6. The agency's policy titled "Grievances and Complaints," # MD-ERR-005.4, effective 9/1/14, states, "5.2. Grievances may be reported via the following methods: ... 5.2.2. Directly to the office providing the care and/or service. ... 5.3. Grievances received from the patient/client and/or family/caregiver will be documented on a Patient Grievance form. 5.3.1. Each employee is responsible for immediate response to reported grievances and should attempt to provide resolution where applicable. 5.3.2. The AM, Director of Clinical Services (DOCS) or designee is responsible to contact the person who filed the grievance and attempt to resolve the issue. Once resolution is achieved, the DOCS, clinical designee or AM will contact and inform the person of the</p>		<p>corrected and will not recur. Completion Date: 2/18/15</p>				

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	<p>resolution and ensure satisfaction.</p> <p>5.3.2.1. The grievance investigation shall begin within 2 business days of receipt.</p> <p>5.3.2.2. The DOCS or AM is responsible for directing the investigation and follow up, and for ensuring resolution. ... 5.4.1. The documentation shall be maintained in the Grievance Binder. ... 5.6 The DOCS, clinical designee and AM are responsible for ensuring that all employees are aware of the process for receiving, reporting, resolving (to the best of their abilities) and documenting any/all patient/client and/or family grievances."</p> <p>7. The agency's policy titled "Patient/Client Rights and Responsibilities," # MD-ERR-001.5, effective 9/1/14, states, "3.2. A patient/client may designate someone to act as his/her representative. This representative, on behalf of the patient/client, may exercise any of the rights provided by the policies and procedures. ... 5.2. Home care patients/clients have the right to: ... 5.2.16. Voice grievances/complaints regarding treatment or care that is or fails to be furnished, lack of respect of property, or recommended changes in policy, staff, or service/care without restraint, interference, coercion, discrimination, or reprisal and to have those grievances/complaints</p>			

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G000120	<p>investigated."</p> <p>484.12(b) DISCLOSURE OF OWNERSHIP & MANAGEMENT The HHA also must disclose the following information to the State survey agency at the time of the HHA's initial request for certification, for each survey, and at the time of any change in ownership or management:</p> <p>(1) The name and address of all persons with an ownership or control interest in the HHA as defined in §§420.201,420.202, and 420.206 of this chapter.</p> <p>(2) The name and address of each person who is an officer, a director, an agent or a managing employee of the HHA as defined in §§420.201, 420.202, and 420.206 of this chapter.</p> <p>(3) The name and address of the corporation, association, or other company that is responsible for the management of the HHA, and the name and address of the chief executive officer and the chairman of the board of directors of that corporation, association, or other company responsible for the management of the HHA. Based on document review and interview, the agency failed to ensure changes in management were disclosed to</p>	G000120	Response to G 120 Disclosure of Ownership and Management Please be aware that the notification was originally sent to	01/27/2015

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	<p>the Indiana State Department of Health (ISDH) for 1 of 1 agency, creating the potential to affect all the agency's patients.</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During interview on 1/14 /15 at 9:10 AM, employee A indicated the new alternate administrator was employee B and they began in August or September of 2014 and ISDH was notified. 2. On 1/14/15 at 11:55 AM, ISDH indicated via email that they would check the system. As of 1/23/15 at 3:30 PM, ISDH had not received a letter of notification with changes in administrative staff. 3. As of 1/23/15 at 3:30 PM, the agency failed to produce a letter of acknowledgement of change in administrative staff from ISDH. 4. During interview on 1/23/15 at 3:00 PM, employee B indicated the corporate office said the letter was sent with the personal services agency change in administration and both letters were sent to one person at ISDH. 		<p>ISDH on July 30, 2014. However, it was sent in the same package with a notification regarding the appointment of a new Administrator on the Company's PSA license. Based on discussions with personnel at ISDH, Company has since learned that the relevant notification was likely intercepted by staff responsible for PSA licensure, and that, per standard ISDH practice, the staff member in question would have disregarded the notification rather than forwarding it to the person responsible for HHA licensure. On 1/23/15, the Company's licensing department re-sent change in Alternate Administrator notification to ISDH attention Bobbie Nelson. To ensure this alleged deficiency does not recur, the Administrator/designee will follow up with the Company licensing department on all change in management notifications sent to ISDH. The Administrator/designee will contact the Company licensing department weekly or until such time that ISDH's acknowledgment of the change notification is received. Going forward, the Company licensing department will make sure that all ISDH notifications are sent separately and addressed to the attention of the staff member who is responsible for the particular license in question. The Accounts</p>		

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G000121	<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. Based on observation, policy review, document review, and interview, the agency failed to ensure staff followed infection control policies and procedures for 4 of 5 home visits, creating the potential to affect all the agency's patients. (#1, 7, 8, and 10)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During home visit observation on 1/20/15 at 1:10 PM, employee E, a home health aide, failed to wash hands for longer than 10 seconds after providing care to patient # 8. 2. During home visit observation on 1/21/15 at 8:30 AM, employee N placed nursing bag directly on patient's floor without a barrier. <p>A. At 8:55 AM, employee Q donned</p>	G000121	<p>Manager/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur. Completion Date: 1/27/15.</p> <p>Response to G 121 Compliance with Accepted Professional Standards We currently have in place infection control policies and procedures that conform to the federal requirements. All skilled and unskilled clinical staff, including Direct Caregivers and Internal Clinical Staff as well as employees N, Q, F, R and A and direct caregivers assigned to patient's #1, 7, 8 and 10, will be re-educated on Infection Control Policies and Procedures, including Company Policy titled "Hand Hygiene". Acknowledgment of re-education completion will be signed by direct caregivers and kept in the Personnel File. All Skilled staff, including Direct Caregivers and Internal Clinical Staff as well as employees N, R and A, will be educated on Bag Technique per Company SOP titled "Bag Technique" and VNAA guideline titled "Infection</p>	02/20/2015

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	<p>gloves, picked up urostomy drainage container to put vinegar into it, went to bathroom to get vinegar bottle and saw there was not enough vinegar in it, so went to kitchen cupboard beside stove to get big bottle of vinegar. Employee Q failed to remove gloves and wash hands or use hand gel prior to touching cupboard in kitchen beside stove.</p> <p>B. At 9:00 AM, employee Q removed gloves and washed hands at kitchen sink and used patient's dish towel to dry hands. Employee Q failed to dry hands on a clean, dry paper towel.</p> <p>3. During home visit observation on 1/21/15 at 12:30 PM, employee F was observed shaving the legs of patient # 10. Employee F placed socks on patient's feet and then proceeded to get a drink for the patient. Employee F failed to wash hands after placing socks on patient.</p> <p>A. Employee F took trash from patient's beside chair to big trash can in garage, then proceeded to get the stander lift ready for patient use. Employee F failed to wash hands after taking trash to garage trash can.</p> <p>B. Employee F provided range of motion to patient's bilateral legs, then proceeded to put own hair into a pony tail</p>		<p>Control-Bag Technique". This education will be mailed to the Direct Caregivers via an in-serviceeducation mailer by 2/6/15. This in-service education will be provided to the internal clinical staff by 2/5/15. This education will be documented and maintained in the QI binder.</p> <p>Beginning 2/16/15, during Supervisory Visits, the Clinical Supervisor will observe the direct caregiver performing Infection Control procedures during Supervisory Visits when a direct caregiver is present. This observation will be documented on the Supervisory Visit note.</p> <p>To ensure this alleged deficiency does not recur, during the quarterly self-audit, the DOCS or designee will review the Supervisory visit notes on 10 or 10% of total patient records, whichever is greater, to ensure the Clinical Supervisors are observing Infection control procedures during Supervisory Visits when direct caregiver is present and documenting this observation on the Supervisory Visit note. Additionally, during the quarterly self-audit, the DOCS or clinical designee will conduct a minimum of 5 patient observation visits and will observe infection control procedures completed by direct caregiver during this visit.</p> <p>The Accounts Manager/designee or Director of Clinical Services/designee will be responsible</p>	

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	<p>and pull the stander lift over to the chair. Employee F failed to wash hands after providing range of motion to patient's legs and failed to wash hands after placing own hair in ponytail.</p> <p>4. During home visit observation on 1/22/15 at 2:00 PM, employee R placed nursing bag directly on dining room chair and failed to use a barrier.</p> <p>5. During interview on 1/23/15 at 1:54 PM, employee A indicated they did not recall a bag technique policy but would expect the staff to use and follow it.</p> <p>6. During interview on 1/23/15 at 2:06 PM, employee B indicated the agency does have a bag technique policy, staff should be following it, and it is available on the company's computer learning portal. Employee B also indicated the agency follows Visiting Nurse Associations of America (VNAA) guidelines for clinical reference.</p> <p>7. During interview on 1/23/15 at 2:08 PM, employee B indicated staff can sing the ABC's to be sure washing hands long enough.</p> <p>8. The agency's policy titled "Hand Hygiene," # MD-ICS-005.3, effective 9/1/14, states, "3.1. Personnel providing</p>		<p>for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur.</p> <p>Completion date: 2/20/15</p>	

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	<p>care or services in the home setting will regularly wash their hands, per the most recently published CDC regulations and guidelines for hand hygiene in health care settings. ... 3.3. When hands are not visibly soiled, they should be decontaminated using an alcohol-based hand rub. ... 4.1.4. Hand decontamination using an alcohol-based hand rub should be performed: 4.1.4.1. Before having direct contact with patients/clients. ... 4.1.4.3. After contact with a patient's/client intact skin. ... 4.1.4.6. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. 4.1.4.7. After removing gloves. ... 4.1.6. Hand Washing with Soap and Water, 4.1.6.1. Equipment, 4.1.6.1.1. Paper towels, 4.1.6.1.2. Liquid soap, 4.1.6.2. Wet hands and apply the soap, and rub hands together vigorously; ... 4.1.6.3. Wash hands for at least 15 seconds covering all surfaces of the hands and fingers. 4.1.6.4. Rinse with water and dry the hands with a disposable towel from the fingers toward the forearm."</p> <p>9. The agency's policy titled "Bag Technique,"# SOP-MD-ICS-001a, effective 9/1/14, states, "1.0 Adhere to Standard Precautions, 2.0 Select a clean flat surface or a doorknob for the bag, 3.0</p>			

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G000134	<p>Place a barrier on flat surface before setting bag down if desired. ...</p> <p>Considerations: ... 2. As homes differ greatly, Direct Care Staff will need to use judgment in selecting an appropriate work area. Considerations include: cleanliness of home, adequate lighting, low traffic area, away from direct currents from windows, heat or air conditioning vents, safe area for bag away from pets and children."</p> <p>10. The VNAA guidelines document for Infection Control-BAG TECHNIQUE, Section 07.01, last updated 9/2012, states, "Considerations: 1. The purpose of bag technique is to reduce the risk of cross-infection between patients via the visit bag and the supplies it contains. 2. The visit bag needs to be kept clean by: ... d. Placing the bag in a "clean" area of home: i. Appropriate areas include placing on a clean hard surface or a paper towel, or hanging on the back of a chair or door knob. ii. Do not contaminate the home with your bag, e.g., do not put on patient's bed, or place wheels of roller bag on patient's furniture."</p> <p>484.14(c) ADMINISTRATOR</p>			

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	<p>The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. Based on employee file review, job description review, policy review, and interview, the administrator failed to ensure all home health aides (HHA) received adequate skills competency prior to being placed in patient homes to provide care for 4 of 8 HHA employee files reviewed, creating the potential to affect all of the agency's 40 HHA only patients. (C, E, F, and L)</p> <p>Findings include</p> <p>1. Employee file C, HHA, date of hire (DOH) 1/5/12, contained a Competency Assessment Worksheet dated 2/15/12. The area labeled "Safe transfer techniques/position and ambulation" failed to evidence which transfer techniques were competency tested and failed to evidence whether the tasks were performed on a pseudo patient or live patient.</p> <p>A. The Aide competency worksheet dated 11/29/13 contained an area labeled "Safe transfer techniques and ambulation" and area labeled "Assistive Devices." These areas failed to evidence which transfer techniques and assistive</p>	G000134	<p>Response to G 134 Administrator HHAs currently assigned to patient #8, including employees E and F, have had competency reassessed on the Hoyer lift using a live person as of 1/22/15. Going forward, all staff assigned to patient#8 will have competency assessed on the Hoyer lift prior to being permitted to perform direct independent patient care. Competencies were documented on the HHAs' competency assessment forms. As further detailed below, competency assessment forms have been updated to specifically indicate Hoyer competency was completed with acknowledgement by the evaluator and the aide that the competency was performed on a live person. HHAs currently assigned to patient #10, including employee F, have had competency assessed on the stander lift as of 1/22/15. Going forward, all staff assigned to patient #10 will have competency assessed on the stander lift prior to being permitted to perform direct independent patient care. 100% review of Medical Records and personnel files will be completed to identify all patients with Hoyer lift and stander lift as</p>	01/27/2015

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	<p>devices were competency tested and failed to evidence whether the tasks were performed on a pseudo patient or live patient.</p> <p>B. The file contained an Annual Aide Competency Worksheet dated 1/17/14. The areas are listed as observation, reporting and documentation of patient status and the care or service furnished, basic infection control procedures, and recognizing emergencies and knowledge of emergency procedures. This worksheet failed to evidence the employee was competenced on care providing skills.</p> <p>2. Employee file E, HHA, DOH 4/13/11, contained an Annual Aide Competency Worksheet dated 5/5/14. The areas are listed as observation, reporting and documentation of patient status and the care or service furnished, basic infection control procedures, and recognizing emergencies and knowledge of emergency procedures. This worksheet failed to evidence the employee was competency tested on care providing skills.</p> <p>A. The Aide competency worksheet dated 4/25/13 evidenced the area labeled "Safe transfer techniques and ambulation" but failed to evidence which</p>		<p>well as all HHAs assigned to patients with Hoyer lifts andstander lift. Each Aide assigned to apatient with a Hoyer lift and/or stander lift, including employees C, E, F andL, will have competency reassessed onthe Hoyer lift and/or stander lift using a live person. Competencies will be documented on the HHAscompetency assessment form. Competencyassessment form will specifically indicate Hoyer competency and/or stander liftcompetency was completed with acknowledgement by the evaluator and the aidethat the competency was performed on a live person by 1/22/15. Aides not re-comped by 1/22/15, or Aidesassessed as not competent in using the Hoyer lift and/or stander lift, will beplaced on Active Restricted status and will be removed from assigned scheduleuntil competency completed and documented appropriately. Once competency re-assessed and aide assessedto be competent in using the Hoyer lift and/or stander lift, aide will beremoved from Active Restricted status and placed on Active status and bepermitted to provide direct independent patient care with patients who haveHoyer or Stander lifts. Aide assessed as not competent in using theHoyer lift and/or stander lift will be placed on Active Restricted status andwill be</p>		

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	<p>transfer techniques were competency tested and failed to evidence whether the tasks were performed on a pseudo patient or live patient.</p> <p>B. The Competency Assessment Worksheet dated 3/1/12 contained an area labeled "Safe transfer techniques/positioning and ambulation." This worksheet failed to evidence which transfer techniques were competency tested and failed to evidence whether the tasks were performed on a pseudo patient or live patient.</p> <p>C. The Competency Assessment Worksheet dated 4/25/11 contained an area labeled "Safe transfer." This worksheet failed to evidence which transfer techniques were competency tested and failed to evidence whether the tasks were performed on a pseudo patient or live patient.</p> <p>D. During interview on 1/15/15 at 9:52 AM, employee E indicated they have worked here 5 years and when they did their initial skills competency with the Hoyer lift, they used a mannequin.</p> <p>3. Employee file F, HHA, DOH 9/10/14, contained an Initial Aide Competency Worksheet dated 9/22/14. The area labeled "Safe transfer techniques and</p>		<p>removed from assigned schedule until competency reassessed. Once competency re-assessed and aide assessed to be competent in using the Hoyer lift and/or stander lift, aide will be removed from Active Restricted status and placed on Active status and be permitted to provide direct independent patient care with patients who have Hoyer lifts and/or stander lift. Ongoing, all HHAs competency assessment forms will be modified to include a checklist of the specific equipment, including Hoyer lift, as well as an area to write in other specific equipment, i.e. stander lift, used during competency assessment. Evaluator and aide will acknowledge, on the competency assessment form, the use of a live person during competency assessments that occur in the office skills lab. DOCS or designee will review all initial and annual/ongoing aide competency assessment forms to ensure proper comps, including the Hoyer and stander lift comp, have been completed on a live person and that the specific equipment is properly documented prior to aide providing direct independent patient care. DOCS or designee will initial bottom corner of competency assessment form to indicate this review was completed. Aides will be placed on Active Restricted Status and will not be permitted to provide</p>				

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	<p>ambulation" failed to evidence which transfer techniques were competency tested and failed to evidence whether the tasks were performed on a pseudo patient or live patient.</p> <p>A. During interview on 1/15/15 at 8:48 AM, employee F indicated they did not have any person in the Hoyer lift when they were competency tested for the skill in the skills lab at Maxim, and they were trained at the patient's home by the other HHA.</p> <p>B. During interview on 1/16/15 at 9:07 AM, employee F indicated they were not asked to be competency tested on the Hoyer again after patient # 8 fell. Employee F indicated they also care for patient # 10 who has a stand up lift, and the previous HHA working at that home trained employee F for everything, including the stand up lift which they had never used prior.</p> <p>C. During home visit observation on 1/21/15 at 12:55 PM, employee S indicated the agency only asked if they have ever used a stander lift before and told them to watch employee F.</p> <p>D. During home visit observation on 1/21/15 at 1:00 PM, patient # 10 indicated the agency has never sent</p>		<p>direct independent patient care until this review is completed and documented. Once the review is complete and documented, the aide will be removed from Active Restricted Status and placed on Active Status and be permitted to provide direct independent patient care. All office staff will be educated on the appropriate competency assessment process, including the existing policy requirement that all unskilled workers shall be assessed using a live person and that the specific equipment must be recorded when performing a competency assessment, by the DOCS and AM/designee. This education will be documented and maintained in the QI binder. Each staff member will sign an acknowledgement form to indicate receipt and understanding of new process. To ensure this alleged deficiency does not recur, during quarterly self-audits, the DOCS or designee will review 10 or 10% of total patient records, whichever is greater as well as 10 or 10% of total personnel files whichever is greater. This review will include an equal mix of Skilled and Unskilled clinical records as well as a mix of skilled and unskilled worker files, to ensure HHA competency Assessments, including Hoyer and stander lift comps, were completed and that the specific equipment used in the assessment is properly</p>	

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	<p>anyone out (nurse) to competency test any of the HHAs on the stander lift, the patient has had to orient the HHAs to the lift themselves, and the agency has it listed as a Hoyer lift on the plan of care.</p> <p>4. Employee file L, HHA, DOH 7/17/14, contained an Initial Aide Competency Worksheet dated 7/29/14. The area labeled "Safe transfer techniques and ambulation" failed to evidence which transfer techniques were competency tested and failed to evidence whether the tasks were performed on a pseudo patient or live patient.</p> <p>5. During interview on 1/14/15 at 2:05 PM, employee A indicated Maxim does use a pseudo patient for skills competency and the "safe transfer techniques and ambulation" section includes Hoyer lift, slide board, and other transfers.</p> <p>6. During interview on 1/14/15 at 2:15 PM, employee I indicated they typically do not do skill competencies in the patients' homes unless there is something the agency does not have in the lab.</p> <p>7. The agency's job description titled "Director of Clinical Services (DOCS)," effective 3/5/13, states, "Essential Duties and Responsibilities: Responsible for</p>		<p>documented as well as to ensure that assigned aides were competency assessed on the relevant transfer equipment. The Accounts Manager/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur. Completion date: 1/27/15</p>	

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	<p>maintaining compliance with applicable local, state, and federal regulations, Company policies and procedures, and accrediting agency requirements. ... Manages and provides to all clinical personnel ongoing education, in-service training programs, and competency evaluations to enhance quality patient care.</p> <p>8. The agency's policy titled "Competency Assessment-Direct Care Staff," # MD-HR-008.6, effective 1/5/15, states, "3.1. The Company is responsible for the design and implementation of its competency assessment program. The Administrative Officer (AO), or designee, is responsible for the ongoing adherence to the competency assessment program for assigned office(s). 3.2. The competence of the Direct Care Staff is accomplished through clinical observation, skills lab demonstration, supervisory visits, knowledge-based tests, situational analysis/case studies, and self-assessment. An employee self-skills assessment tool alone is not sufficient to evaluate competency. ... 3.2.2. For unskilled staff (HHA, CNA, etc.) the competency assessment must be performed on a person. The use of a mannequin for unskilled staff skills competency assessment is not acceptable. The evaluation may occur in the</p>			

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	<p>patient/client's residence, the office skills laboratory, a skilled nursing facility, hospital, or other healthcare facility. 3.3. Competency assessment is conducted initially during orientation and annually thereafter. ... 3.3.3. No Direct Care Staff may independently provide care to a patient without having previously been deemed as competent to provide the care for the assigned patient. ... 3.4. An established protocol will be used as a guideline for competency assessment. 3.4.1. The reference for the protocols is the most current version of the Visiting Nurses of America Nursing Procedure Manual. ... 3.5.1.1. For each competency assessment which requires the evaluation of the employee's management or use of a piece of equipment or supplies and the specific piece of equipment or supplies is not available in the office, the DOCS or clinical designee may arrange for the equipment validation component of the competency assessment to be completed in an alternate location. ... 5.4.1.3. The following competencies must be evaluated while the aide is performing the task with a person: ... 5.4.1.3.9. Safe transfer techniques and ambulation. ... 5.5.1. Annual competency assessment must be completed at least annually (onetime per calendar year). Additional competencies may be required for change</p>			

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	<p>in patient assignment, performance issues, new technology or other indications at the discretion of the DOCS or clinical designee."</p> <p>9. The agency's policy titled "Patient/Client Scheduling," # MD-CL-016.4, effective 9/1/14, states, "3.3. Patient/client scheduling requires communication between the Director of Clinical Services (DOCS) or clinical designee and the assigned scheduler. The DOCS or clinical designee is responsible for identifying the appropriate and competent Direct Care Staff eligible for a particular patient/client assignment and informing the scheduler of particular patient/client requirements. The scheduler is then responsible for selecting qualified Direct Care Staff from the pool of appropriate and competent Direct Care Staff. The scheduler may not assign an employee to a patient/client that has not been deemed as competent to provide care to a particular patient/client without approval from the DOCS or clinical designee. This approval is documented and maintained in the medical record. ... 5.5. Following the initial visit, the DOCS or clinical designee identifies any client specific needs or clinical competencies required for assignment and communicate these to the scheduler. 5.1.1. Client specific needs may include</p>			

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G000156	<p>but not be limited to the following: ...</p> <p>5.1.1.2. Skill, education, training and availability of direct Care Staff."</p> <p>10. The agency's policy titled "Home Health Certification and Plan(s) of Care," # HH-CL-007.6, effective 11/10/14, states "Policy ... 3.7. ... No clinical assignment will be made unless the Direct Care Staff has had competencies assessed as required for the specific assignment. These competencies are based on the same VNAA procedures. 4. Definitions 4.1. Direct Care Staff: Those individuals that provide or direct care to the patient's in his/her home or alternate care setting."</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record review, policy review, and interview, it was determined the agency failed to ensure the frequencies and hours of services ordered on the plan of care were met for 3 of 10 clinical records reviewed (See G 158); failed to ensure Plans of Care included all durable medical equipment used by the patient for 1 of 5 home visit observations (See G 159); and failed to promptly inform the physician of a significant change in condition for 1 of 10 clinical records reviewed (See G 164), creating</p>	G000156	<p>Response to G 156 and G158 Acceptance of Patients, POC, Medical Supervision</p> <p>All internal office staff, including employee J, will receive re-education on Company SOP titled "Missed Shift/Visit" by 2/20/15. This education will be documented and maintained in the QI binder.</p> <p>Clinical record #1: Weekly nursing visits staffed consistently since 1/29/15.</p> <p>Clinical record #5: Patient transferred to another home health</p>	02/20/2015

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	<p>the potential to affect all the agency's 73 patients.</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.18, Acceptance of Patients, Plan of Care, and Medical Supervision.</p>		<p>provider and was discharged on 1/26/15.</p> <p>Clinical record #10: Patient has been staffed consistently since 1/18/15. A new office process has been developed which will include the recruiters calling all primary and secondary direct caregivers to check availability to meet the staffing requirement per the plan of care. If the primary and secondary direct caregivers are unavailable, qualified staff will be reviewed as an option with the patient & primary caregiver; if acceptable, the new staff will receive a patient specific orientation from the Maxim Clinical Supervisor/clinical designee prior to working the shift. Measures have been taken by the Administrator to ensure that appropriate clinical staff in the office is made aware of any failures to cover a shift, gaps in coverage, to ensure that our efforts are coordinated effectively and support the plan of care. Measures have been taken by the Administrator to ensure a contractual agreement with the Maxim Staffing Solution to assist with providing a qualified caregiver in the event an open shift cannot be filled by the HomeHealth Agency's own employee pool. If no staff is available, the patient, primary caregiver, physician and patient's case manager are notified and alternate forms of care are discussed. All communications will be recorded in the system of record.</p>	

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NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4646 W JEFFERSON BLVD STE 100 FORT WAYNE, IN 46804
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			<p>If it is identified that staffingunavailability will not be intermittent but long term, then there will beincreased recruitment efforts.</p> <p>If these increased efforts to staff the patient perphysician ordered frequency are not effective, then we will refer to thedischarge policy because we will have met one of the criteria for dischargethat states available personnel are adequate for the continuing needs of theclient and notify our legal representative for guidance.</p> <p>The Administrator/designee will educate all Internal Officestaff on new office process by 2/20/15. This education will be documented and maintained in the QI binder.</p> <p>The Administrator/designee or Director of ClinicalServices/designee will assume responsibility to ensure adherence to staffingper the plan of care, discharge policy, and contacting physicians and casemanagers to assist with alternative staffing plans to meet the needs of thepatient. During quarterly self- audits, the Administrator/designee will review10 or 10% of total patient records, whichever is greater, to ensure thatstaffing was provided per the plan of care as well as to ensure thatpatient/caregiver, physician and case manager were notified of missed shifts.</p> <p>The Administrator/designee will be responsible formonitoring these</p>	

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G000158	<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. Based on clinical record review, policy review, and interview, the agency failed to ensure the frequencies and hours of services ordered on the plan of care (POC) were met for 3 of 10 clinical records reviewed, creating the potential to affect all the agency's patients. (# 1, 5, and 10)</p> <p>Findings include</p> <p>1. Clinical record #1, start of care (SOC) date 12/30/13, contained a POC dated 12/25/14-2/22/15 with orders for skilled nurse (SN) 1 time a week for urostomy change and as needed for 60 days and home health aide (HHA) 17-28 hours a week for 60 days.</p> <p>A. The clinical record failed to evidence a SN visit was conducted on 1/1/15 and 1/15/15.</p> <p>B. During interview on 1/21/15 at</p>	G000158	<p>corrective actions to ensure that the alleged deficiency is corrected and will not recur. Completion date: 2/20/15</p> <p>Response to G158 Acceptance of Patients, POC, Medical Supervision All internal office staff, including employee J, will receive re-education on Company SOP titled "Missed Shift/Visit" by 2/20/15. This education will be documented and maintained in the QI binder. Clinical record #1: Weekly nursing visits staffed consistently since 1/29/15. Clinical record #5: Patient transferred to another home health provider and was discharged on 1/26/15. Clinical record #10: Patient has been staffed consistently since 1/18/15. A new office process has been developed which will include the recruiters calling all primary and secondary direct caregivers to check availability to meet the staffing requirement per the plan of care. If the primary and secondary direct caregivers are unavailable, qualified staff will be reviewed as an option with the patient & primary caregiver; if acceptable, the new staff will</p>	02/20/2015

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	<p>3:30 PM, employee B indicated there were missed visits on this patient.</p> <p>C. The Communication Noted dated 1/20/15 at 9:46 AM, evidenced employee J called the patient and the nurse about the missed visits and the client said parent was helping out and they have been calling the nurse directly to cancel the visits, and the nurse said patient did notify them.</p> <p>D. During interview on 1/21/15 at 4:20 PM, employee A indicated best practice for notifying physician of missed visits is within 14 days.</p> <p>2. Clinical record # 5, SOC date 7/22/13, contained a POC dated 11/14/14-1/12/15 with orders for SN 50-84 hours per week for 60 days, client eligible for respite SN services not to exceed 720 hour for authorized dates.</p> <p>A. The record failed to evidence SN services were provided on 11/23/14 for 12 hours, 11/25/14 for 6 hours, and 11/27/14 for 12 hours. The Missed Visit form dated 12/10/14 evidenced the reason being "Unable to backfill registered nurse (RN) / licensed practical nurse(LPN)."</p> <p>B. During interview on 1/23/15 at</p>		<p>receive a patient specific orientation from theMaxim Clinical Supervisor/clinical designee prior to working the shift. Measures have been taken by the Administrator to ensure that appropriate clinical staff in the office is made aware of anyfailures to cover a shift, gaps in coverage, to ensure that our efforts arecoordinated effectively and support the plan of care. Measures have been taken by the Administrator to ensure acontractual agreement with the Maxim Staffing Solution to assist with providinga qualified caregiver in the event an open shift cannot be filled by the HomeHealth Agency's own employee pool. If no staff is available, the patient,primary caregiver, physician and patient's case manager are notified andalternate forms of care are discussed. All communications will be recorded in the system of record. If it is identified that staffingunavailability will not be intermittent but long term, then there will beincreased recruitment efforts. If these increased efforts to staff the patient perphysician ordered frequency are not effective, then we will refer to thedischarge policy because we will have met one of the criteria for dischargethat states available personnel are adequate for the continuing needs of theclient and notify our legal representative for guidance. The</p>				

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	<p>8:50 AM, employee B indicated unable to backfill means they did not have an option to cover the shifts due to call offs by staff, unable to find staff, and/or other various reasons.</p> <p>C. The record failed to evidence any loggings of missed visit communication with patient or primary caregiver for the missed dates.</p> <p>3. Clinical record # 10, SOC date 9/15/14, contained a POC dated 11/14/14-1/12/15 with orders for HHA 25-42 hours per week for 60 days.</p> <p>A. The record failed to evidence 25 hours were provided the weeks of 12/14-12/20/14 and 12/21-12/27/14.</p> <p>B. The Missed Visit form dated 12/19/14 for the HHA shift stated the reason being "Unable to backfill Aide," and was signed on 1/14/15 by employee J. This form states Notification was to physician, Director of Clinical Services (DOCS), Case Manager, and Family and/or Caregiver, as evidenced by check marks in the boxes noted YES.</p> <p>C. The Missed Visit form dated 12/22/14 and 12/25/14 for the HHA shift stated the reason being "Unable to backfill Aide," and was signed on</p>		<p>Administrator/designee will educate all Internal Office staff on new office process by 2/20/15. This education will be documented and maintained in the QI binder. The Administrator/designee or Director of Clinical Services/designee will assume responsibility to ensure adherence to staffing per the plan of care, discharge policy, and contacting physicians and casemanagers to assist with alternative staffing plans to meet the needs of the patient. During quarterly self-audits, the Administrator/designee will review 10 or 10% of total patient records, whichever is greater, to ensure that staffing was provided per the plan of care as well as to ensure that patient/caregiver, physician and case manager were notified of missed shifts. The Administrator/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur. Completion date: 2/20/15</p>				

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	<p>1/14/15 by employee J. This form states Notification was to physician, DOCS, Case Manager, and Family and/or Caregiver, as evidenced by check marks in the boxes noted YES.</p> <p>D. The communication note dated 1/21/15 at 1:40 PM evidenced the physician was not notified of the missed visits for 12/8/14, 12/9/14, 12/19/14, 12/22/14, and 12/25/14 until 1/21/15 and stated, "due to problem with transmitting fax we did not receive a fax communications sheet."</p> <p>E. During interview on 1/22/15 at 9:54 AM, employees A and B indicated a nurse covered the shifts for 1.5 hours on 12/20 and 12/21/14 but the nurse did not document on a HHA sheet, and did not complete any form of documentation.</p> <p>4. The agency's policy titled "Missed Shift/Visit," # SOP-MD-CL-016b, effective 9/1/14, states "Missed shift, A missed shift occurs when the patient's scheduled shift is not completed according to the physician order for the assigned date and hours. ... If at any time the services provided do not match the physician order (or range of orders) a Missed Shift/Visit Note and notification of the physician is required. The medical record will include all documentation</p>				

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	<p>related to the missed shift including alternative care for the patient. ...</p> <p>Process Step 1.0 Notify Office of Potential Missed Shift/Visit, performed by patient and/or direct care staff, as soon as possible, The patient and/or Direct Care Staff should notify the office of a potential missed shift/visit as soon as possible. ... 4.0 Notify patient/Family Caregiver that No Back-up Staff is Available, Performed by AM/Recruiter/DOCS/Designee, Once all options are exhausted, If the office is unable to identify substitute staff, notify the patient/family so that they may assume responsibility for patient care until such time as staff becomes available. ... 5.0 Notify Physician, per DOCS/Clinical Designee Discretion, ...</p> <p>The office may notify the patient's physician and, as applicable, any others that require notification of the missed shift/visit. Note: ... Physician notification is good practice, but is required when the missed shift/visit causes the care to fall below the physician ordered frequency. ... 6.0 ...</p> <p>Cancel the shift/visit in the system of record and updated System to reflect reason far missed shift/visit. ... 8.0 ...</p> <p>The office will review the physician order to determine whether the missed shift/visit causes the care frequency to fall outside of the shift/visit frequency</p>			

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G000159	<p>ordered by the physician. If the care is not within the frequency of shifts/visits ordered by the physician, notify the DOCS or Clinical Designee to evaluate if the program and/or payor source requires an order range/frequency of care/services prescribed. If necessary, the DOCS or clinical designee will need to obtain a supplemental order from the physician."</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on clinical record review, observation, policy review, and</p>	G000159	Response to G 159 Plan of Care Internal Clinical Staff will be educated on Company Policytitled	02/20/2015

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	<p>interview, the agency failed to ensure Plans of Care (POC) included all durable medical equipment (DME) used by the patient for 1 of 5 home visit observations creating the potential to affect all the agency's 73 patients. (# 10)</p> <p>Findings include</p> <p>1. Clinical record # 10, start of care date 9/15/14, contained a POC dated 11/14/14-1/12/15 and a POC dated 1/13-3/13/15 with DME listed as Hoyer lift. During home visit observation on 1/21/15 at 1:00 PM, DME noted in home included a stander lift, called a Get-U-Up lift.</p> <p>A. During home visit observation on 1/21/15 at 1:00 PM, patient # 10 indicated the agency has never sent anyone out (nurse) to competency test any of the home health aides (HHA) on the stander lift, the patient has had to orient the HHAs to the lift themselves, and the agency has it listed as a Hoyer lift on the plan of care.</p> <p>B. The Aide Care Plan dated 9/15/14 and reviewed on 11/11/14 and 1/8/15 stated "Hoyer lift" in the transfer/assist section.</p> <p>C. During interview on 1/21/15 at</p>		<p>"Home Health Certification and Plan of Care" as well as the requirement for the Plan of Care to include all Durable Medical Equipment (DME) used by the patient. This education will be completed by 2/13/15 and documentation of the education will be maintained in the QI binder. Clinical record for patient #10 will be reviewed and Plan of Care updated to include proper Stander Lift. Additionally 100% of medical records will be reviewed, including clinical record for patient #10, to ensure that all Plans of Care include all DME used by the patient by 2/20/15.</p> <p>To ensure this alleged deficiency does not recur, during the quarterly self-audit, the DOCS or designee will review the Plans of Care on 10 or 10% of total patient records, whichever is greater, to ensure the Plan of Care includes all DME used by the patient. Additionally, during the quarterly self-audit, the DOCS or clinical designee will conduct a minimum of 5 patient observation visits and will compare the DME in the home with the DME listed on the Plans of Care to ensure the Plan of Care includes all DME used by the patient.</p> <p>The Accounts Manager/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur.</p>	

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G000164	<p>2:38 PM, employee A indicated the agency did not know this patient had a different lift and not a Hoyer lift.</p> <p>2. The agency's policy titled "Home Health Certification and Plan(s) of Care," # HH-CL-007.6, effective 11/10/14, states "5.3. The Plan of Care shall include, but not limited to: ... 5.3.4. Listing of equipment and supplies."</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on clinical record review, policy review, and interview, the agency failed to promptly inform the physician of a significant change in condition for 1 of 10 clinical records reviewed, creating the potential to affect all the agency's 73 patients. (# 8)</p> <p>Findings include</p> <p>1. Clinical record # 8, start of care date 5/4/09, contained a plan of care (POC) dated 11/6/14-1/4/15 with a diagnosis of Multiple Sclerosis and orders for home health aide (HHA) 34-56 hours a week times 60 days and skilled nursing (SN) 1 visit three times weekly times 60 days. The POC contained general orders for SN</p>	G000164	<p>Completion Date: 2/20/15</p> <p>Response to G 164 Periodic Review of Plan of Care Internal Clinical Staff will be re-educated on Company Policy titled "Physician Responsibility in Managing Care" to include therequirement to promptly inform the physician of a significant change in patientcondition as well as the requirement to document the physician notification inthe clinical record. This education willbe completed by 2/13/15 and documentation of the education to be maintained inthe QI binder. Beginning 2/16/15, the DOCS or designee will track allreports of changes in patient condition, including patient #8, to ensure thatrequired follow up, including notification to physician, has</p>	02/20/2015

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	<p>as skilled observation and assessment every shift and as needed for signs of distress including: ... pain and symptom control, ... safety measures, ... mental status. ... signs and symptoms of abnormalities to any of the above are to be reported to the MD.</p> <p>A. The clinical document dated 11/30/14 by employee F, HHA, stated "Around 10 AM I was getting [patient] up had [patient] in Hoyer lift. I pulled the Hoyer lift out and than turned [patient] so feet wouldn't drop on the bed and [patient] fell. When I looked down the hooks were still connected to the blue pad underneath [patient]. So I hurried and unhooked them to check [patient] out. [Patient] wanted me to get [patient] up so I re-hooked the Hoyer lift got [patient] in chair like [patient] requested. I then called Maxim and I told [employee J] everything that happened. [employee J] told me a nurse would call me. When nurse did [nurse] asked what happened I told [nurse] and told [nurse] [patient] had a knot on [patient's] left side head and that [patient's] left shoulder hurt, [nurse] told me to call 911 and to call [nurse] back. So I called 911 and they came to access [patient] and check [patient] vitals, they did and said everything was fine, asked [patient] if [patient] wanted to go in, [patient refused] and then told me</p>		<p>occurred per Company policy. DOCS or designee will review the change in condition tracker, as well as applicable patient record, weekly, to validate that the physician was promptly notified of any significant change in patient condition.</p> <p>To ensure this alleged deficiency does not recur, during the quarterly self-audit, the DOCS or designee will review 10 or 10% of total patient records, whichever is greater, to ensure that the physician was promptly notified of any significant changes in patient condition.</p> <p>The Accounts Manager/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur.</p> <p>Completion Date: 2/20/15</p>	

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	<p>to just keep an eye on [patient]. I called the nurse back, told [nurse] what was going on and [nurse] told me also to keep an eye on [patient] and write a clinical documentation."</p> <p>B. During interview on 1/14/15 at 12:05 PM, employee A indicated when a patient falls in the home, the policy is the HHA should call 911 and when the patient is safe then the HHA needs to call the office. If the patient refuses EMS we go do a change in condition visit. On 11/30/14 after the patient fell, the HHA notified the office first, and then 911 was called and the HHA reported the EMS said the patient was stable. Employee A indicated that on 12/1/14 the normal HHA went to care for the patient and called the office saying the patient reported they were not feeling right, so the HHA called 911 and the patient was taken to the emergency room, and found out the patient had a broken shoulder.</p> <p>C. The clinical record failed to evidence the physician was notified of the patient's fall until 12/9/14. Note: This fall resulted in the patient having a fractured shoulder.</p> <p>D. During interview on 1/15/15 at 12:30 PM, employee A indicated they notified the physician on 12/9/14 of the</p>			

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	<p>incident from 11/30/14 as soon as they found out it had not yet been reported.</p> <p>2. During interview on 1/22/15 at 10:30 AM, employees A and B indicated the agency has weekly care coordination meetings to discuss staff issues etc and these are mandatory for everyone, otherwise the communication notes in the computer are to be used for care coordination.</p> <p>3. The agency's policy titled "Physician Responsibility in Managing Care," # MD-CL-005.3, effective 9/1/14, states "4.3. The office's role will include but is not limited to: ... 4.3.1. Timely communication to physician regarding his/her patient to include: 4.3.1.1. Changes in the patient condition. ... 4.3.3. To assist in continuity of care, including ongoing updates, written summaries, and phone consultation."</p>				

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G000168	<p>484.30 SKILLED NURSING SERVICES</p> <p>Based on clinical record review, policy review, and interview, it was determined the agency failed to ensure the registered nurse re-evaluated the patient within 24 hours post fall for 1 of 10 clinical records reviewed (See G 172); failed to ensure Plans of Care included all durable medical equipment used by the patient for 1 of 5 home visit observations (See G 173); and failed to ensure the registered nurse informed the physician of changes in patient's condition for 1 of 10 clinical records reviewed (See G 176).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.30 Nursing Service.</p>	G000168	<p>Response to G 168 Skilled Nursing Services and G172 Duties of Registered Nurse</p> <p>Internal Clinical Staff, including employee A (Employee V is no longer employed), will be re-educated on Company Policy titled "Assessment", including the State/Program Specific section for Indiana requirement for a registered nurse (RN) to determine whether the patient's situation requires immediate attention and EMS (911) should be called or whether an assessment is required within 24 hours post fall. This education will be completed by 2/13/15 and will be maintained in the QI binder. Beginning 2/16/15, the office will track all reports of changes in patient condition, including patient #8, to ensure that the required RN follow-up, and/or re-evaluation of the patient, was completed per policy. DOCS or designee will review the change in condition tracker, as well as applicable patient record, weekly, to validate that the required RN follow-up, and/or re-evaluation of the patient, was completed and documented in the patient record.</p> <p>To ensure this alleged deficiency does not recur, during the quarterly self-audit, the DOCS or designee will review 10 or 10% of total patient</p>	02/20/2015

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G000172	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse (RN) re-evaluated the patient within 24 hours post fall for 1 of 10 clinical records reviewed, creating the potential to affect all the agency's 73 patients. (# 8)</p> <p>Findings include</p> <p>1. Clinical record # 8, start of care (SOC) date 5/4/09, contained a plan of care (POC) dated 11/6/14-1/4/15 with a diagnosis of Multiple Sclerosis and orders for home health aide (HHA) 34-56 hours a week times 60 days and skilled nursing (SN) 1 visit three times weekly times 60 days. The POC contained general orders for SN as skilled observation and assessment every shift</p>	G000172	<p>records, whichever is greater, to ensure that required RN follow-up, and/or re-evaluation of the patient, was completed with all changes in patient condition. The Accounts Manager/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur. Completion Date: 2/20/15</p> <p>Response to G172 Duties of Registered Nurse Internal Clinical Staff, including employee A (Employee V is no longer employed), will be re-educated on Company Policy titled "Assessment", including the State/Program Specific section for Indiana requirement for a registered nurse (RN) to determine whether the patient's situation requires immediate attention and EMS (911) should be called or whether an assessment is required within 24 hours post fall. This education will be completed by 2/13/15 and will be maintained in the QI binder. Beginning 2/16/15, the office will track all reports of changes in patient condition, including patient #8, to ensure that the required RN follow-up, and/or re-evaluation of</p>	02/20/2015

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	<p>and as needed for signs of distress including: ... pain and symptom control, ... safety measures, ... mental status. ... signs and symptoms of abnormalities to any of the above are to be reported to the MD.</p> <p>A. The clinical documentation dated 11/30/14 by employee F, HHA, stated "Around 10 AM I was getting [patient] up had [patient] in Hoyer lift. I pulled the Hoyer lift out and than turned [patient] so feet wouldn't drop fro the bed and [patient] fell. When I looked down the hooks were still connected to the blue pad underneath [patient]. So I hurried and unhooked them to check [patient] out. [Patient] wanted me to get [patient] up so I re-hooked the Hoyer lift got [patient] in chair like [patient] requested. I then called Maxim and I told [employee J] everything that happened. [employee J] told me a nurse would call me. When nurse did [nurse] asked what happened I told [nurse] and told [nurse] [patient] had a knot on [patient's] left side head and that [patient's] left shoulder hurt, [nurse] told me to call 911 and to call [nurse] back. So I called 911 and they came to access [patient] and check [patient] vitals, they did and said everything was fine, asked [patient] if [patient] wanted to go in, [patient refused] and then told me to just keep an eye on [patient]. I called</p>		<p>the patient, was completed perpolicy. DOCS or designee will review thechange in condition tracker, as well as applicable patient record, weekly, tovalidate that the required RN follow-up, and/or re-evaluation of the patient,was completed and documented in the patient record.</p> <p>To ensure this alleged deficiency does not recur, during thequarterly self-audit, the DOCS or designee will review 10 or 10% of totalpatient records, whichever is greater, to ensure that required RN follow-up,and/or re-evaluation of the patient, was completed with all changes in patientcondition. The Accounts Manager/designee or Director of ClinicalServices/designee will be responsible for monitoring these corrective actionsto ensure that the alleged deficiency is corrected and will not recur.</p> <p>Completion Date: 2/20/15</p>	

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	<p>the nurse back , told [nurse] what was going on and [nurse] told me also to keep an eye on [patient] and write a clinical documentation."</p> <p>B. During interview on 1/14/15 at 12:05 PM, employee A indicated when a patient falls in the home, the policy is the HHA should call 911 and when the patient is safe then the HHA needs to call the office. If the patient refuses EMS we go do a change in condition visit. On 11/30/14 after the patient fell, the HHA notified the office first, and then 911 was called and the HHA reported the EMS said the patient was stable. Employee A indicated that on 12/1/14 the normal HHA went to care for the patient and called the office saying the patient reported they were not feeling right, so the HHA called 911 and the patient was taken to the emergency room, and found out the patient had a broken shoulder.</p> <p>C. The On-Call log evidenced on 11/30/14 at 10:19 AM that employee F notified employee V, the clinical supervisor, that the patient had fallen in the Hoyer lift, said patient was back up and ok, and employee V directed HHA to take vital signs and had the clinician on call contact HHA, and employee V followed up with patient's primary care giver (PCG).</p>						

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	<p>D. During interview on 1/15/15 at 1:20 PM, employee V indicated they were on call on 11/30/14 and spoke with the HHA (employee F) after patient # 10 fell from the Hoyer lift. Employee V indicated they instructed the HHA to call 911. Employee V indicated policy is the patient does not get moved before calling 911. Employee V indicated the HHA told them the patient did not lose consciousness and did not hit their head. Employee V indicated the policy for assessing a patient post fall is 911 is to be utilized- if during regular hours, the clinical supervisor needs to assess the patient for a significant change in condition. Employee V indicated the HHA told them the patient was "OK." Employee V indicated this was per paramedic evaluation of what is normal for the patient, and the patient had no signs or symptoms of injury, or complaints, and the EMS deemed the patient to be stable and not needing medical treatment, the patient is alert and oriented, and if the EMS had any questions they can always ask the HHA there. Employee V indicated EMS personnel are of a higher level of care provider than a nurse so we have to trust their judgment, just like we would a physician. Employee V indicated the agency nurse does not have to do</p>			
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	<p>anything else unless there are any notable changes like bruising or etcetera.</p> <p>Employee V indicated if transferred to the emergency room and sent home with no issues, the agency does not have to do anything further if the emergency room said the patient was ok, but if the patient was admitted for over 24 hours, then we would do a resumption of care.</p> <p>Employee V indicated if there are changes within 24 hours of the fall time, then they would go assess the patient, but nobody is going to wait that long if the patient refuses everything else.</p> <p>E. The clinical record failed to evidence the patient was assessed by a nurse until 12/1/14 at 4:30 PM. The care coordination note evidenced the patient returned home from the hospital on 12/1/14 at 2:00 PM.</p> <p>F. During interview on 1/14/15 at 12:08 PM, employee A indicated the nurse did not go assess the patient until 12/1/14 due to the EMS said the patient was stable on 11/30/14. Employee A indicated the policy says the agency has 24 hours to see the patient post fall. Employee A indicated this was an unwitnessed fall and the patient's PCG went to help get the patient back in bed. Employee A indicated the durable medical equipment (DME) company</p>			

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G000173	<p>evaluated the Hoyer lift after the fall, but the agency did not receive a copy of that report but was told by the PCG that there was not a problem with the Hoyer lift.</p> <p>2. The agency's policy titled "Assessment," # MD-CL-004.3, effective 9/1/14, states, "6. State/Program Specific requirement: Indiana For Home Health Aide (HHA) cases the HHA will notify the clinical supervisor immediately for all changes in patient condition such as Falls, Injuries, Pain, or Illness. A Registered Nurse (RN) will make a determination whether the patient's situation requires immediate attention and emergency medical response (911) should be called or whether an assessment is required within 24 hours of agency knowledge."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record review, observation, policy review, and interview, the agency failed to ensure the registered nurse updated the Plan of Care (POC) with the correct durable medical equipment (DME) used by the patient for</p>	G000173	<p>Response to G 173 Duties of the Registered Nurse Internal Clinical Staff will be educated on Company Policy titled "Home Health Certification and Plan of Care" as well as the requirement for the Plan of Care to</p>	02/20/2015

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	<p>1 of 5 home visit observations creating the potential to affect all the agency's 73 patients. (# 10)</p> <p>Findings include</p> <p>1. Clinical record # 10, start of care date 9/15/14, contained a POC dated 11/14/14-1/12/15 and a POC dated 1/13-3/13/15 with DME listed as Hoyer lift. During home visit observation on 1/21/15 at 1:00 PM, DME noted in home included a stander lift, called a Get-U-Up lift.</p> <p>A. During home visit observation on 1/21/15 at 1:00 PM, patient # 10 indicated the agency has never sent anyone out (nurse) to competency test any of the home health aides (HHA) on the stander lift, the patient has had to orient the HHAs to the lift themselves, and the agency has it listed as a Hoyer lift on the plan of care.</p> <p>B. The Aide Care Plan dated 9/15/14 and reviewed on 11/11/14 and 1/8/15 stated "Hoyer lift" in the transfer/assist section.</p> <p>C. During interview on 1/21/15 at 2:38 PM, employee A indicated the agency did not know this patient had a different lift and not a Hoyer lift.</p>		<p>include all Durable Medical Equipment (DME) used by the patient. This education will be completed by 2/13/15 and documentation of the education will be maintained in the Q binder. Clinical record for patient #10 will be reviewed and Plan of Care updated to include proper Stander Lift. Additionally 100% of medical records will be reviewed, including clinical record for patient #10, to ensure that all Plans of Care include all DME used by the patient by 2/20/15.</p> <p>To ensure this alleged deficiency does not recur, during the quarterly self-audit, the DOCS or designee will review the Plans of Care on 10 or 10% of total patient records, whichever is greater, to ensure the Plan of Care includes all DME used by the patient. Additionally, during the quarterly self-audit, the DOCS or clinical designee will conduct a minimum of 5 patient observation visits and will compare the DME in the home with the DME listed on the Plans of Care to ensure the Plan of Care includes all DME used by the patient.</p> <p>The Accounts Manager/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur.</p> <p>Completion Date: 2/20/15</p>	

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G000176	<p>2. The agency's policy titled "Home Health Certification and Plan(s) of Care," # HH-CL-007.6, effective 11/10/14, states "5.3. The Plan of Care shall include, but not limited to: ... 5.3.4. Listing of equipment and supplies."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on clinical record review, policy review, and interview, the agency failed to inform the physician of a change in condition for 1 of 10 clinical records reviewed, creating the potential to affect all the agency's 73 patients. (# 8)</p> <p>Findings include</p> <p>1. Clinical record # 8, start of care date 5/4/09, contained a plan of care (POC) dated 11/6/14-1/4/15 with a diagnosis of Multiple Sclerosis and orders for home health aide (HHA) 34-56 hours a week times 60 days and skilled nursing (SN) 1 visit three times weekly times 60 days. The POC contained general orders for SN as skilled observation and assessment</p>	G000176	<p>Response to G 176 Duties of the Registered Nurse Internal Clinical Staff will be re-educated on Company Policy titled "Physician Responsibility in Managing Care" to include therequirement to promptly inform the physician of a significant change in patientcondition as well as the requirement to document the physician notification inthe clinical record. This education willbe completed by 2/13/15 and documentation of the education to be maintained inthe QI binder. Beginning 2/16/15, the DOCS or designee will track allreports of changes in patient condition, including patient #8, to ensure thatrequired follow up, including notification to physician, has</p>	02/20/2015

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	<p>every shift and as needed for signs of distress including: ... pain and symptom control, ... safety measures, ... mental status. ... signs and symptoms of abnormalities to any of the above are to be reported to the MD.</p> <p>A. The clinical document dated 11/30/14 by employee F, HHA, stated "Around 10 AM I was getting [patient] up had [patient] in Hoyer lift. I pulled the Hoyer lift out and than turned [patient] so feet wouldn't drop on the bed and [patient] fell. When I looked down the hooks were still connected to the blue pad underneath [patient]. So I hurried and unhooked them to check [patient] out. [Patient] wanted me to get [patient] up so I re-hooked the Hoyer lift got [patient] in chair like [patient] requested. I then called Maxim and I told [employee J] everything that happened. [employee J] told me a nurse would call me. When nurse did [nurse] asked what happened I told [nurse] and told [nurse] [patient] had a knot on [patient's] left side head and that [patient's] left shoulder hurt, [nurse] told me to call 911 and to call [nurse] back. So I called 911 and they came to access [patient] and check [patient] vitals, they did and said everything was fine, asked [patient] if [patient] wanted to go in, [patient refused] and then told me to just keep an eye on [patient]. I called</p>		<p>occurred per Company policy. DOCS or designee will review the change in condition tracker, as well as applicable patient record, weekly, to validate that the physician was promptly notified of any significant change in patient condition.</p> <p>To ensure this alleged deficiency does not recur, during the quarterly self-audit, the DOCS or designee will review 10 or 10% of total patient records, whichever is greater, to ensure that the physician was promptly notified of any significant changes in patient condition.</p> <p>The Accounts Manager/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur.</p> <p>Completion Date: 2/20/15</p>	

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	<p>the nurse back, told [nurse] what was going on and [nurse] told me also to keep an eye on [patient] and write a clinical documentation."</p> <p>B. During interview on 1/14/15 at 12:05 PM, employee A indicated when a patient falls in the home, the policy is the HHA should call 911 and when the patient is safe then the HHA needs to call the office. If the patient refuses EMS we go do a change in condition visit. On 11/30/14 after the patient fell, the HHA notified the office first, and then 911 was called and the HHA reported the EMS said the patient was stable. Employee A indicated that on 12/1/14 the normal HHA went to care for the patient and called the office saying the patient reported they were not feeling right, so the HHA called 911 and the patient was taken to the emergency room, and found out the patient had a broken shoulder.</p> <p>C. The clinical record failed to evidence the physician was notified of the patient's fall until 12/9/14. Note: This fall resulted in the patient having a fractured shoulder.</p> <p>D. During interview on 1/15/15 at 12:30 PM, employee A indicated they notified the physician on 12/9/14 of the incident from 11/30/14 as soon as they</p>			

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G000202	<p>found out it had not yet been reported.</p> <p>2. During interview on 1/22/15 at 10:30 AM, employees A and B indicated the agency has weekly care coordination meetings to discuss staff issues etc and these are mandatory for everyone, otherwise the communication notes in the computer are to be used for care coordination.</p> <p>3. The agency's policy titled "Physician Responsibility in Managing Care," # MD-CL-005.3, effective 9/1/14, states "4.3. The office's role will include but is not limited to: ... 4.3.1. Timely communication to physician regarding his/her patient to include: 4.3.1.1. Changes in the patient condition. ... 4.3.3. To assist in continuity of care, including ongoing updates, written summaries, and phone consultation."</p> <p>484.36 HOME HEALTH AIDE SERVICES Based on home visit observation, policy review, job description review, and interview, it was determined the agency</p>	G000202	Response to G 202 & G 212 Home Health Aide and Competency evaluation and In-Service training HHAs currently	01/27/2015

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	<p>failed to ensure all home health aides (HHA) received adequate skills competency testing prior to being placed in patient homes to provide care for for 2 of 10 clinical records reviewed, creating the potential to affect all the agency's patients (See G 212), failed to ensure home health aides were trained by a registered nurse for 4 of 8 HHA employee files reviewed, creating the potential to affect all of the agency's 40 HHA only patients (See G 217), failed to ensure the registered nurse prepared the HHA assignment sheets according to physician orders for 1 of 5 records reviewed of patients receiving HHA services, creating the potential to affect all the agency's patients who receive HHA services (See G 224), and failed to ensure the HHA followed the Aide Care Plans ordered by the physicians for 2 of 10 clinical records reviewed of patients receiving HHA services, creating the potential to affect all the agency's 73 patients receiving HHA services (See G 225).</p> <p>The cumulative effect of these systemic problems resulted in the agency being unable to provide safe home health aide services.</p> <p>This deficient practice resulted in an immediate jeopardy (IJ). The IJ was</p>		<p>assigned to patient #8, including employees E and F, have had competency reassessed on the Hoyer lift using a live person as of 1/22/15. Going forward, all staff assigned to patient #8 will have competency assessed on the Hoyer lift, as well as all skills the aide is to perform on this patient, prior to being permitted to perform direct independent patient care. Competencies are documented on the HHAs' competency assessment forms. As further detailed below, competency assessment forms have been updated to specifically indicate Hoyer competency was completed with acknowledgement by the evaluator and the aide that the competency was performed on a live person.</p> <p>HHAs currently assigned to patient #10, including employee F, have had competency assessed on the stander lift on as of 1/23/15. Going forward, all staff assigned to patient #10 will have competency assessed on the stander lift, as well as all skills the aide is to perform on this patient, prior to being permitted to perform direct independent patient care. 100% review of Medical Records and personnel files will be completed to identify all patients with Hoyer lift and stander lift as well as all HHAs assigned to patients with Hoyer lifts and stander lift. Each Aide assigned to a patient with a Hoyer lift and/or stander lift,</p>		

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	<p>identified on 1/16/15 at 1:30 PM, with regard to failure to ensure proper Hoyer and/or lift competency testing with HHAs prior to assigning to patients with Hoyer, or other lifts, resulting in injury of a left humerus fracture to patient #8; failure to competency test HHAs with pseudo patients or live patients per employee interviews; and failure to document specific Hoyer/lift transfer competencies for HHAs. Employees A and B were notified of the IJ on 1/16/15 at 1:30 PM. The IJ was removed on 1/23/15, but the agency remained out of compliance as the agency had competency tested 31 of 31 current HHAs providing services to patients with Hoyer lifts/stander lifts. Continuation of HHA skills competency testing for the remaining HHAs needed to continue the following week. The agency provided documents for review on 1/23/15 which evidenced the 31 HHAs assigned to Hoyer lift patients had received the competency test updates in relation to the IJ. The agency evidenced the HHA competency forms were changed to include specific durable medical equipment skills being competency tested, and included box to check if the skill was performed on a live or pseudo patient. Condition level noncompliance remains at G 212 as Maxim was still coordinating competency testing the remaining home</p>		<p>including employees C, E, F and L, will have competency reassessed on the Hoyerlift and/or stander lift using a live person. Competencies will be documented on the HHAs competency assessmentform. Competency assessment form willspecifically indicate Hoyer competency and/or stander lift competency wascompleted with acknowledgement by the evaluator and the aide that thecompetency was performed on a live person by 1/22/15. Aides not re-comped by 1/22/15, or Aidesassessed as not competent in using the Hoyer lift and/or stander lift, will beplaced on Active Restricted status and will be removed from assigned scheduleuntil competency completed and documented appropriately. Once competency re-assessed and aide assessedto be competent in using the Hoyer lift and/or stander lift, aide will beremoved from Active Restricted status and placed on Active status and bepermitted to provide direct independent patient care with patients who haveHoyer or Stander lifts. Aide assessed as not competent in using theHoyer lift and/or stander lift, or any other skill the aide is to perform, will be placed on Active Restricted status andwill be removed from assigned schedule until competency reassessed. Once competency re-assessed and aide assessedto be</p>	

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	health aides. An inservice was conducted with all the recruiters about complaints and was completed on 1/20/15,. This was verified by inservice documentation.		competent, aide will be removed from Active Restricted status and placed on Active status and be permitted to provide direct independent patient care. Ongoing, all HHAs competency assessment forms will be modified to include a checklist of the specific equipment, including Hoyer lift, as well as an area to write in other specific equipment, i.e. stander lift, used during competency assessment. Evaluator and aide will acknowledge, on the competency assessment form, the use of a live person during competency assessments that occur in the office skills lab. DOCS or designee will review all initial and annual/ongoing aide competency assessment forms to ensure proper comps, including the Hoyer and stander lift comp, have been completed on a live person and that the specific equipment is properly documented prior to aide providing direct independent patient care. DOCS or designee will initial bottom corner of competency assessment form to indicate this review was completed. Aides will be placed on Active Restricted Status and will not be permitted to provide direct independent patient care until this review is completed and documented. Once the review is complete and documented, the aide will be removed from Active Restricted Status and placed on Active	

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			Status and be permitted to provide direct independent patient care. All office staff will be educated on the appropriate competency assessment process, including the existing policy requirement that all unskilled workers shall be assessed using a live person and that the specific equipment must be recorded when performing a competency assessment, by the DOCS and AM/designee. This education will be documented and maintained in the QI binder. Each staff member will sign an acknowledgement form to indicate receipt and understanding of new process. In addition to the Standard cited, the statement of deficiency included allegations that are more fully discussed the corrections for items G107/N514 (Exercise of Rights and Respect for Property) and G173/N542 (Duties of the Registered Nurse). To ensure this alleged deficiency does not recur, during quarterly self-audits, the DOCS or designee will review 10 or 10% of total patient records, whichever is greater as well as 10 or 10% of total personnel files whichever is greater. This review will include an equal mix of Skilled and Unskilled clinical records as well as a mix of skilled and unskilled worker files, to ensure HHA competency Assessments, including Hoyer and stander lift comps, as well as all skills the aide is to perform,	

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G000212	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAINING</p> <p>The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.</p> <p>Based on home visit observation, clinical record review, policy review, and interview, the agency failed to ensure all home health aides (HHA) received adequate Hoyer lift/stander lift skills competency testing prior to being placed in patient homes to provide care for 2 of 10 clinical records reviewed, resulting in a fall with injury of left shoulder fracture to patient #8, creating the potential to affect all the agency's 40 HHA only patients. (# 8 and 10)</p> <p>This deficient practice resulted in an immediate jeopardy (IJ). The IJ was</p>	G000212	<p>were completed and that the specific equipment used in the assessment is properly documented as well as to ensure that assigned aides were competency assessed on the relevant transfer equipment. The Accounts Manager/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur. Completion date: 1/27/15</p> <p>Response to G 212 Home Health Aide and Competency evaluation and In-Service training HHAs currently assigned to patient #8, including employees E and F, have had competency reassessed on the Hoyer lift using a live person as of 1/22/15. Going forward, all staff assigned to patient #8 will have competency assessed on the Hoyer lift, as well as all skills the aide is to perform on this patient, prior to being permitted to perform direct independent patient care. Competencies are documented on the HHAs' competency assessment forms. As further detailed below,</p>	01/27/2015	

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	<p>identified on 1/16/15 at 1:30 PM, with regard to failure to ensure proper Hoyer and/or lift competency testing with HHAs prior to assigning to patients with Hoyer, or other lifts, resulting in injury of a left shoulder to patient #8; failure to competency test HHAs with pseudo patients or live patients per employee interviews; and failure to document specific Hoyer/lift transfer competencies for HHAs. Employees A and B were notified of the IJ on 1/16/15 at 1:30 PM. The IJ was removed on 1/23/15, but the agency remained out of compliance as the agency had competency tested 31 of 31 current HHAs providing services to patients with Hoyer lifts/stander lifts. Continuation of HHA skills competency testing for the remaining HHAs needed to continue the following week. The agency provided documents for review on 1/23/15 which evidenced the 31 HHAs assigned to Hoyer lift patients had received the competency testing updates in relation to the IJ. The agency evidenced the HHA competency forms were changed to include specific durable medical equipment skills being competency tested, and included a box to check if the skill was performed on a live or pseudo patient. Condition level remains at G 212 out of compliance as Maxim was still coordinating competency testing for the remaining</p>		<p>competency assessment forms have been updated to specifically indicate Hoyer competency was completed with acknowledgement by the evaluator and the aide that the competency was performed on a live person. HHAs currently assigned to patient #10, including employee F, have had competency assessed on the stander lift on as of 1/23/15. Going forward, all staff assigned to patient #10 will have competency assessed on the stander lift, as well as all skills the aide is to perform on this patient, prior to being permitted to perform direct independent patient care. 100% review of Medical Records and personnel files will be completed to identify all patients with Hoyer lift and stander lift as well as all HHAs assigned to patients with Hoyer lifts and stander lift. Each Aide assigned to a patient with a Hoyer lift and/or stander lift, including employees C, E, F and L, will have competency reassessed on the Hoyer lift and/or stander lift using a live person. Competencies will be documented on the HHAs competency assessment form. Competency assessment form will specifically indicate Hoyer competency and/or stander lift competency was completed with acknowledgement by the evaluator and the aide that the competency was performed on a live person by 1/22/15.</p>	

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	<p>home health aides. An inservice was conducted with all the recruiters about complaints and was completed on 1/20/15. This was verified by inservice documentation.</p> <p>Findings include</p> <p>1. Clinical record # 8 start of care (SOC) date 5/4/09, contained a plan of care (POC) dated 11/6/14-1/4/15 with a diagnosis of Multiple Sclerosis and orders for home health aide (HHA) 34-56 hours a week times 60 days and skilled nursing (SN) 1 visit three times weekly times 60 days. The POC contained general orders for SN as follows: skilled observation and assessment every shift and as needed for signs of distress including: ... pain and symptom control, ... safety measures, ... mental status. ... signs and symptoms of abnormalities to any of the above are to be reported to the MD."</p> <p>A. The clinical documentation dated 11/30/14 by employee F, HHA, stated, "Around 10 AM I was getting [patient] up had [patient] in Hoyer lift. I pulled the Hoyer lift out and then turned [patient] so feet wouldn't drop on the bed and [patient] fell. When I looked down the hooks were still connected to the blue pad underneath [patient]. So I hurried</p>		<p>Aides not re-comped by 1/22/15, or Aides assessed as not competent in using the Hoyer lift and/or stander lift, will be placed on Active Restricted status and will be removed from assigned schedule until competency completed and documented appropriately. Once competency re-assessed and aide assessed to be competent in using the Hoyer lift and/or stander lift, aide will be removed from Active Restricted status and placed on Active status and be permitted to provide direct independent patient care with patients who have Hoyer or Stander lifts. Aide assessed as not competent in using the Hoyer lift and/or stander lift, or any other skill the aide is to perform, will be placed on Active Restricted status and will be removed from assigned schedule until competency reassessed. Once competency re-assessed and aide assessed to be competent, aide will be removed from Active Restricted status and placed on Active status and be permitted to provide direct independent patient care.</p> <p>Ongoing, all HHAs competency assessment forms will be modified to include a checklist of the specific equipment, including Hoyer lift, as well as an area to write in other specific equipment, i.e. stander lift, used during competency assessment. Evaluator and aide will acknowledge, on the</p>				

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	<p>and unhooked them to check [patient] out. [Patient] wanted me to get [patient] up so I re-hooked the Hoyer lift got [patient] in chair like [patient] requested. I then called Maxim and I told [employee J] everything that happened. [employee J] told me a nurse would call me. When nurse did [nurse] asked what happened I told [nurse] and told [nurse] [patient] had a knot on [patient's] left side head and that [patient's] left shoulder hurt, [nurse] told me to call 911 and to call [nurse] back. So I called 911 and they came to assess [patient] and check [patient] vitals, they did and said everything was fine, asked [patient] if [patient] wanted to go in, [patient refused] and then told me to just keep an eye on [patient]. I called the nurse back , told [nurse] what was going on and [nurse] told me also to keep an eye on [patient] and write a clinical documentation."</p> <p>B. During interview on 1/15/15 at 8:48 AM, employee F indicated on 11/30/14, they had the Hoyer lift cranked up and when turning out so the patient's feet would be off the bed, the patient fell. Employee F indicated the patient landed on the floor on their left side and on the Hoyer lift legs and had fallen kind of head first, and one side of the Hoyer pad was still hooked to the lift, and the only part that came off was still hooked to the</p>		<p>competency assessment form, the use of a live person during competency assessments that occur in the office skills lab. DOCS or designee will review all initial and annual/ongoing aide competency assessment forms to ensure proper comps, including the Hoyer and stander lift comp, have been completed on a live person and that the specific equipment is properly documented prior to aide providing direct independent patient care. DOCS or designee will initial bottom corner of competency assessment form to indicate this review was completed. Aides will be placed on Active Restricted Status and will not be permitted to provide direct independent patient care until this review is completed and documented. Once the review is complete and documented, the aide will be removed from Active Restricted Status and placed on Active Status and be permitted to provide direct independent patient care. All office staff will be educated on the appropriate competency assessment process, including the existing policy requirement that all unskilled workers shall be assessed using a live person and that the specific equipment must be recorded when performing a competency assessment, by the DOCS and AM/designee. This education will be documented and maintained in the QI binder. Each staff member will sign</p>	

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	<p>pad. Employee F indicated they then used the Hoyer lift to get the patient up into the chair because the patient requested. Employee F indicated the patient did hit their head during the fall and had a knot on the head but did not complain about it. Employee F indicated they called Maxim and then called 911, and the emergency medical technicians (EMTs) said patient was fine and they asked patient if they wanted to go to the hospital but the patient refused and didn't even want the HHA to call 911 to begin with. Employee F indicated no nurse from Maxim came to the house to evaluate the patient but the nurse on call had spoken to employee F and told them to check if patient's head hurts or if patient dozes off. Employee F indicated the patient had no complaints the rest of the shift. Employee F indicated they did not put anyone in the Hoyer lift when they demonstrated competency in the lab at the office, and employee E trained them in the home. Employee F indicated they were going to call state but Maxim put them on leave for 1.5 months. Employee F indicated they were re-educated with testing, handbook, and was told to just double check everything with assigned tasks, but the agency did not review safety precautions again and did not have them go back into the office for re-training on the Hoyer lift, and they</p>		<p>anacknowledgement form to indicate receipt and understanding of new process. In addition to the Standard cited, the statement of deficiency included allegations that are more fully discussed the corrections for items G107/N514 (Exercise of Rights and Respect for Property) and G173/N542 (Duties of the Registered Nurse). To ensure this alleged deficiency does not recur, during quarterly self-audits, the DOCS or designee will review 10 or 10% of total patient records, whichever is greater as well as 10 or 10% of total personnel files whichever is greater. This review will include an equal mix of Skilled and Unskilled clinical records as well as a mix of skilled and unskilled worker files, to ensure HHA competency Assessments, including Hoyer and stander lift comps, as well as all skills the aide is to perform, were completed and that the specific equipment used in the assessment is properly documented as well as to ensure that assigned aides were competency assessed on the relevant transfer equipment. The Accounts Manager/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur. Completion date: 1/27/15</p>				

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	<p>were only ever shown how to use the Hoyer and were not trained.</p> <p>C. The Aide Weekly Note dated 11/30/14 at 3:50-9:00 PM stated, patient "refused range of motion because [patient] is sore from fall in the AM."</p> <p>D. The clinical record failed to evidence the physician was notified of the patient's fall until 12/9/14.</p> <p>E. The On-Call log evidenced on 11/30/14 at 10:19 AM that employee F notified employee V, the clinical supervisor, that the patient had fallen in the Hoyer lift, said patient was back up and ok, and employee V directed HHA to take vital signs and had the clinician on call contact HHA, and employee V followed up with patient's primary care giver (PCG).</p> <p>F. During interview on 1/15/15 at 1:20 PM, employee V indicated they were on call on 11/30/14 and spoke with the HHA (employee F) after patient # 10 fell from the Hoyer lift. Employee V indicated they instructed the HHA to call 911. Employee V indicated policy is the patient does not get moved before calling 911. Employee V indicated the HHA told them the patient did not lose consciousness and did not hit their head.</p>						

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	<p>Employee V indicated the policy for assessing a patient post fall is 911 is to be utilized- if during regular hours, the clinical supervisor needs to assess the patient for a significant change in condition. Employee V indicated the HHA told them the patient was "OK." Employee V indicated this was per paramedic evaluation of what is normal for the patient, and the patient had no signs or symptoms of injury, or complaints, and the EMS deemed the patient to be stable and not needing medical treatment, the patient is alert and oriented, and if the EMS had any questions they can always ask the HHA there. Employee V indicated EMS personnel are of a higher level of care provider than a nurse so we have to trust their judgment, just like we would a physician. Employee V indicated the agency nurse does not have to do anything else unless there are any notable changes like bruising or etcetera. Employee V indicated if transferred to the emergency room and sent home with no issues, the agency does not have to do anything further if the emergency room said the patient was ok, but if the patient was admitted for over 24 hours, then we would do a resumption of care. Employee V indicated if there are changes within 24 hours of the fall time, then they would go assess the patient, but</p>			

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	<p>nobody is going to wait that long if the patient refuses everything else.</p> <p>G. The On-Call log evidenced on 11/30/14 at 10:22 AM, employee F reported the EMS had come and gone and patient was not transported and patient was "OK."</p> <p>H. The clinical record failed to evidence the patient was assessed by a nurse until 12/1/14 at 4:30 PM. The care coordination note evidenced the patient returned home from the hospital on 12/1/14 at 2:00 PM.</p> <p>I. The Communication Note dated 12/2/14 evidenced employee E, HHA, called the office on 12/1/14 to report the patient was in pain, had a bump on head, and shoulder was swollen, and patient was requesting to go to the emergency room. This communication note also stated, "The client had a broken left arm resulting in a mobilizer being placed. Client was given pain medication and sent home later in the afternoon."</p> <p>J. The clinical record failed to evidence the agency obtained any reports from Emergency Medical System (EMS) for 11/30/14 and 12/1/14, and failed to evidence any reports from the hospital for 12/1/14.</p>			

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	<p>K. During interview on 1/14/15 at 12:05 PM, employee A indicated when a patient falls in the home, the policy is the HHA should call 911 and when the patient is safe then the HHA needs to call the office. If the patient refuses EMS we go do a change in condition visit. On 11/30/14 after the patient fell, the HHA notified the office first, and then 911 was called and the HHA reported the EMS said the patient was stable. Employee A indicated that on 12/1/14 the normal HHA went to care for the patient and called the office saying the patient reported they were not feeling right, so the HHA called 911 and the patient was taken to the emergency room, and found out the patient had a broken shoulder.</p> <p>L. During interview on 1/14/15 at 12:08 PM, employee A indicated the nurse did not go assess the patient until 12/1/14 due to the EMS said the patient was stable on 11/30/14. Employee A indicated the policy says the agency has 24 hours to see the patient post fall. Employee A indicated this was an unwitnessed fall and the patient's PCG went to help get the patient back in bed. Employee A indicated the durable medical equipment (DME) company evaluated the Hoyer lift after the fall, but the agency did not receive a copy of that</p>			

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	<p>report but was told by the PCG that there was not a problem with the Hoyer lift.</p> <p>M. During interview on 1/14/15 at 12:12 PM, employee A indicated the HHA should not have moved the patient, but the patient insisted on being moved so the HHA used the Hoyer to get the patient up into the chair prior to calling the office. Employee A indicated the HHA reported the chain buckled on the Hoyer lift and the patient fell out of it.</p> <p>N. During interview on 1/15/15 at 11:10 AM, employee A indicated the agency does not get the emergency reports for patients unless the patients are admitted to the hospital, so the hospitals do not even know the patient is a Maxim patient unless they are admitted. Employee A indicated the agency reviews emergency room discharge instructions, if there are any, once the patient gets home, otherwise they go by what the patients say following an emergency room visit.</p> <p>O. On 1/15/15 the agency obtained the EMS and hospital reports per surveyor request. The EMS report dated 11/30/14 evidenced the chief complaint to be shoulder pain; onset of event occurred 5 minutes prior to calling EMS. Head/neck section evidenced pupil were perrl, no</p>			

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	<p>JVD or deviation noted. At 10:50 AM, EMS evidenced the patient did not want to be transported to the hospital and was asked several times, patient was advised on all the risks of signing off including up to death, patient understood, and signed refusal. The EMS narrative note stated, "Patient was using a Hoyer lift when one of the chains became disconnected and patient fell to the ground landing on [patient's] left side. ... Patient noted to have a hematoma to the left forehead above the eye. Patient stated paint to the left shoulder."</p> <p>P. The EMS report dated 12/1/14 at 9:56 AM evidenced the chief complaint was left upper arm pain and swelling and bruising. Patient was transported to Kosciusko Community Hospital.</p> <p>Q. The EMS report dated 12/1/14 at 12:38 PM, evidenced the patient was transported back home with a chief complaint of closed fracture neck of humerus.</p> <p>R. The Kosciusko Community Hospital records dated 12/1/14 evidence the chief complaint was soft tissue injury to left shoulder. Triage note stated "patient fell during transfer yesterday with Hoyer lift, EMS was called, patient was checked and signed off. Patient</p>			

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	<p>complains of onset left humerus and shoulder pain today." Discharge instructions stated "humerus fracture, treated with immobilization." Patient was discharged with Hydrocodone Bitartrate-Acetaminophen Oral tablet 5-325 milligrams 1 tablet every 6 hours for pain.</p> <p>S. The orthopedic consultation dated 12/1/14 stated, "Diagnostic data: X-rays demonstrated displaced surgical neck fracture with some impaction and displacement, ... this mild displacement might otherwise require surgical treatment in someone who is functional with that extremity. ... Emergency room diagnosis: left surgical neck fracture of the proximal humerus."</p> <p>T. The X-ray report dated 12/1/14 stated, "Impression: Comminuted fracture of the left humeral head with rotation and displacement of the humeral head fragment as well as some impaction of the humeral shaft. Surgical consultation is recommended."</p> <p>U. During interview on 1/16/15 at 10:40 AM, employee A indicated employee F has returned to work this week on 1/12/15 and has since reviewed the safety module, but still needs to take the test on the computer. Employee A</p>			

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	<p>indicated the computer safety test is annual and is a one and done but they found out yesterday they can print it out. Employee A indicated the agency does not have the report from the DME company that checked the Hoyer lift, but the patient's PCG told the agency the Hoyer was checked and it was okay. Employee A indicated the root cause of the Hoyer lift incident was human error. Employee A indicated when employee F came in for interview on 12/1/14 to begin the incident investigation, employee F demonstrated what happened using the Hoyer lift in the agency lab.</p> <p>V. During interview on 1/20/15 at 9:20 AM, surveyor spoke with patient #8's PCG via telephone. PCG indicated there have been a few HHAs sent to care for the patient that the patient was not comfortable with because they were not getting the Hoyer pad placed right, and so we asked the office for more training with those HHAs. PCG indicated the Hoyer chain did not break and they had the DME company check it after the fall and they said there was nothing wrong with it, and now the patient will not let anyone get them up with it if it does not feel right. PCG indicated they usually spoke with employee H at the office about re-training the HHAs, but they have also spoken with employee A and</p>			

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	<p>employee J in the past but they don't think employee H pushed the issue. And that was 2 weeks ago. PCG indicated they last spoke with employee A about it before the fall happened. PCG indicated the patient does need surgery on the shoulder but the physician said it would cause more pain and difficulty in rolling the patient to be changed and due to other health issues and age it is not advisable, so the patient will always have pain now.</p> <p>2. During home visit observation on 1/20/15 at 12:50 PM, patient #8 indicated their family member told agency employee H, several times, that employee C needed to be re-trained on the Hoyer lift but that never happened.</p> <p>3. The agency complaint log failed to evidence any complaints about home health aides (HHA) needing to be re-trained.</p> <p>4. During interview on 1/15/15 at 9:52 AM, employee E indicated some of the HHAs sent to patient #8's home do not know how to use a Hoyer lift, don't know how to use the Hoyer pad or position it, and don't know how to hook it up. Employee E indicated one HHA actually tried to put the hole in the pad over the patient's head.</p>			

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	<p>5. During interview on 1/16/15 at 11:02 AM, employee H indicated they have had people call and say HHA need more experience with Hoyer lift, but cannot recall how recent or any specific names. Employee H indicated at that point they would contact the educator, employee I, and they would bring the employee in for more training or have them paired up with the most tenured HHA for the specific patient and do a 2 hour training session. Employee H indicated the HHA come to the office initially for training.</p> <p>6. At 11:20 AM, employee H indicated these complaints/concerns go under worker loggings, but it is not saved anywhere and there is constant communication with the client, so the agency would call the client and see if the HHA received more training in the home before they would send/schedule that HHA with that patient again.</p> <p>7. During interview on 1/16/15 at 11:30 AM, employee I indicated if an HHA is not comfortable with equipment/skill, they have the HHA come back into the office and competency the HHA again until they are comfortable with that equipment/skill. Employee I indicated they usually do not have recruiters tell them a HHA needs more training, and have not had any reported to them.</p>			

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	<p>Employee I indicated they have the HHA re-train with the primary HHA that is familiar with the client specific case, but this does not happen often. Employee I indicated after the initial skills competency, they set up 1:1 HHA to HHA for re-training.</p> <p>8. During interview on 1/16/15 at 1:50 PM, employee A indicated they have not heard of any requests, complaints, or concerns of HHA need re-training.</p> <p>9. During interview on 1/23/15 at 3:00 PM, employee A indicated they should have been notified of complaints or concerns related to patient safety issues.</p> <p>10. Clinical record # 10, SOC date 9/15/14, contained a POC dated 11/14/14-1/12/15 with orders for HHA 25-42 hours per week for 60 days. DME listed included Hoyer lift. During home visit observation on 1/21/15 at 1:00 PM, DME noted in home included a stander lift, called a Get-U-Up lift.</p> <p>A. During home visit observation on 1/21/15 at 1:00 PM, patient # 10 indicated the agency has never sent anyone out (nurse) to competency any of the HHAs on the stander lift, the patient has had to orient the HHAs to the lift themselves, and the agency has it listed</p>			

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	<p>as a Hoyer lift on the plan of care.</p> <p>B. During interview on 1/16/15 at 9:07 AM, employee F indicated they were not asked to be competency tested on the Hoyer again after patient # 8 fell. Employee F indicated they also care for patient # 10 who has a stand up lift, and the previous HHA working at that home trained employee F for everything, including the stand up lift which they had never used prior. Employee F indicated when they were initially hired on at Maxim, they were only shown how to use the Hoyer.</p> <p>C. During home visit observation on 1/21/15 at 12:55 PM, employee S indicated the agency only asked if they have ever used a stander lift before and told them to watch employee F.</p> <p>D. The Aide Care Plan dated 9/15/14 and reviewed on 11/11/14 and 1/8/15 stated "Hoyer lift" in the transfer/assist section.</p> <p>E. During interview on 1/21/15 at 2:38 PM, employee A indicated the agency did not know this patient had a different lift and not a Hoyer lift.</p> <p>F. Clinical record # 10 contained a communication note dated 12/22/14 at</p>			

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	<p>11:20 AM, stated, "Informed client that we were able to get staff to [patient] at 4:45 p with [employee W], HHA. [Employee W] is going to train [employee X]." This was signed as entered by employee J.</p> <p>11. During interview on 1/22/15 at 10:30 AM, employees A and B indicated the agency has weekly care coordination meetings to discuss staff issues etc and these are mandatory for everyone, otherwise the communication notes in the computer are to be used for care coordination.</p> <p>12. The agency's policy titled "Care Coordination/Case Conference," # MD-CL-018.6, effective 9/1/14, states, "2. Purpose: 2.1. to ensure coordination of services for each patient and to minimize the potential for missed, conflicting, or duplicated services. 2.2. To facilitate effective communication amongst the health care team. 3. Policy: 3.1. Care coordination is accomplished through communication with the members of the health care team. 3.2. Interdisciplinary coordination of care is ensured through communication and case conferencing. ... 5. Procedure: 5.1. Direct Care Staff shall communicate changes in patient status amongst the assigned personnel and the Director of</p>			

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	<p>Clinical Services (DOCS) or clinical designee. 5.2. Direct Care Staff will communicate changes in a timely manner via telephone, one-to-one meetings, case conferences and/or home visits. Documentation of communications will be included in the medical record on a communication note, case conference note, clinical visit note, supervisory visit note or in the system of record. ... Documentation will include; the date and time of the communication, individuals involved with the communication, information discussed, and the outcome of the communication.</p> <p>5.3. Contents of the Case Conference note may include, but are not limited to: 5.3.1. Current clinical status, 5.3.2. Changes or updates in treatment plan, 5.3.3. Patient response to interventions, 5.3.4. Progress toward goals, ... 5.3.6. Non-clinical issues."</p> <p>13. The agency's policy titled "Assessment," # MD-CL-004.3, effective 9/1/14, states, "3.4. The reassessment of the patient shall be completed at regular intervals or as frequently as the patient/client's condition warrants due to a major decline or improvement in health status. ... 3.6.2. The comprehensive assessments must be conducted by a registered nurse. ... 3.6.3. A follow-up comprehensive assessment or</p>			

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	<p>recertification is conducted by a qualified clinician to identify the patient's current health status and continued need(s) for home health services. 3.6.7.2. The purpose of the initial assessment is to evaluate the immediate care/service and support needs of the patient. ... 3.6.7.3. The plan of service is reviewed at least once every 60 days or when there is a change in the client/patient's response to therapy, when physician orders change, or at the request of the patient/client. ... 3.6.9. The plan of care/service review will include documentation in the record which demonstrates consideration of the plan of service for: 3.6.9.4. Changes in patient/client's condition. 4. Definitions: ... 4.2. Qualified clinician: A Registered Nurse, unless Physical, Occupational Therapy or Speech Language Pathology is the only qualifying service for that patient. ... The clinician who is responsible for evaluation and coordination of services for the patient. ... 5. Procedure: 5.1. The DOCS or designee will confirm that a qualified clinician is assigned to complete the comprehensive assessment within the appropriate timelines for admission, ROC, and/or reassessment of the patient/client. 5.1.1. The qualified clinician shall notify the Director of Clinical Services (DOCS) or clinical designee and/or physician of assessment</p>			

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	<p>findings or when there is a change in the patient condition which might warrant a change in medication and/or a change to the plan of care/service. ... 6.</p> <p>State/Program Specific requirement: Indiana For Home Health Aide (HHA) cases the HHA will notify the clinical supervisor immediately for all changes in patient condition such as Falls, Injuries, Pain, or Illness. A Registered Nurse (RN) will make a determination whether the patient's situation requires immediate attention and emergency medical response (911) should be called or whether an assessment is required within 24 hours of agency knowledge."</p> <p>14. The agency's policy titled "Physician Responsibility in Managing Care," # MD-CL-005.3, effective 9/1/14, states, "4.3. The office's role will include but is not limited to: 4.3.1. Timely communication to physician regarding his/her patient to include: 4.3.1.1. Changes in the patient condition. ... 4.3.3. To assist in continuity of care, including ongoing updates, written summaries, and phone consultation."</p> <p>15. The agency's policy titled "Home Health Certification and Plan(s) of Care," # HH-CL-007.6, effective 11/10/14, states, "Policy ... 3.7. ... No clinical assignment will be made unless the</p>						

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G000217	<p>Direct Care Staff has had competencies assessed as required for the specific assignment. These competencies are based on the same VNAA procedures. 4. Definitions 4.1. Direct Care Staff: Those individuals that provide or direct care to the patient's in his/her home or alternate care setting."</p> <p>484.36(b)(3)(ii) COMPETENCY EVALUATION & IN-SERVICE TRAI The competency evaluation must be performed by a registered nurse. The in-service training generally must be supervised by a registered nurse who possesses a minimum of 2 years of nursing experience at least 1 year of which must be in the provision of home health care. Based on employee file review, job description review, policy review, and interview, the agency failed to ensure home health aides (HHA) were trained by a registered nurse for 4 of 8 HHA employee files reviewed, creating the potential to affect all of the agency's 40 HHA only patients. (C, E, F, and L)</p> <p>Findings include</p>	G000217	Response to G 217 Competency Evaluation and In-Service Training HHAs currently assigned to patient #8, including employees E and F, have had competency reassessed by an RN on the Hoyer lift using a live person as of 1/22/15. Going forward, all staff assigned to patient #8 will have competency assessed by an RN on the Hoyer lift, as well as all other DME used and skills the aide is to perform on this patient, prior to being permitted to perform direct	01/27/2015

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	<p>1. During interview on 1/15/15 at 8:48 AM, employee F indicated they did not have any person in the Hoyer lift when they were competency tested for the skill in the skills lab at Maxim, and they were trained at the patient's home by the other HHA.</p> <p>2. During interview on 1/16/15 at 9:07 AM, employee F indicated they were not asked to be competency tested on the Hoyer again after patient # 8 fell. Employee F indicated they also care for patient # 10 who has a stand up lift, and the previous HHA working at that home trained employee F for everything, including the stand up lift which they had never used prior.</p> <p>3. During home visit observation on 1/21/15 at 12:55 PM, employee S indicated the agency only asked if they have ever used a stander lift before and told them to watch employee F.</p> <p>4. During home visit observation on 1/21/15 at 1:00 PM, patient # 10 indicated the agency has never sent anyone out (nurse) to competency test any of the HHAs on the stander lift, the patient has had to orient the HHAs to the lift themselves, and the agency has it listed as a Hoyer lift on the plan of care.</p>		<p>independent patient care.</p> <p>Competencies are documented on the HHAs' competency assessment forms. As further detailed below, competency assessment forms have been updated to specifically indicate the type of DME used in the competency assessment, including the Hoyer lift, as well as to include an acknowledgement by the evaluator and the aide that the competency was performed on a live person.</p> <p>HHAs currently assigned to patient #10, including employee F, have had competency assessed by an RN on the stander lift on as of 1/22/15. Going forward, all staff assigned to patient #10 will have competency assessed by an RN on the stander lift, as well as other DME used and skills the aide is to perform on this patient, prior to being permitted to perform direct independent patient care. Competencies are documented on the HHAs' competency assessment forms.</p> <p>100% review of Medical Records and personnel files will be completed to identify all patients with Hoyer lift and stander lift, as well as all HHAs assigned to patients with Hoyer lifts and stander lift. Each Aide assigned to a patient with a Hoyer lift and/or stander lift, including employees C, E, F and L, will have competency reassessed by an RN on the Hoyer lift</p>	

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	<p>5. During interview on 1/14/15 at 2:15 PM, employee I indicated they typically do not do skill competencies in the patients' homes unless there is something the agency does not have in the lab.</p> <p>6. The agency's job description titled "Director of Clinical Services (DOCS)," effective 3/5/13, states, "Essential Duties and Responsibilities: Responsible for maintaining compliance with applicable local, state, and federal regulations, Company policies and procedures, and accrediting agency requirements. ... Manages and providers to all clinical personnel ongoing education, in-service training programs, and competency evaluations to enhance quality patient care.</p> <p>7. The agency's policy titled "Competency Assessment-Direct Care Staff," # MD-HR-008.6, effective 1/5/15, states, "3.1. The Company is responsible for the design and implementation of its competency assessment program. ... 3.2.2. For unskilled staff (HHA, CNA, etc.) the competency assessment must be performed on a person. The use of a mannequin for unskilled staff skills competency assessment is not acceptable. The evaluation may occur in the patient/client's residence, the office skills laboratory, a skilled nursing facility,</p>		<p>and/or stander lift using a live person. Competencies will be documented on the HHAscompetency assessment form. Competencyassessment form will specifically indicate Hoyer competency and/or stander liftcompetency was completed with acknowledgement by the evaluator and the aide that the competency was performed on a live person by 1/22/15. Aides not re-comped by 1/22/15, or Aidesassessed as not competent in using the Hoyer lift and/or stander lift, will beplaced on Active Restricted status and will be removed from assigned scheduleuntil competency completed and documented appropriately. Once competency re-assessed and aide assessedto be competent in using the Hoyer lift and/or stander lift, aide will beremoved from Active Restricted status and placed on Active status and bepermitted to provide direct independent patient care with patients who haveHoyer or Stander lifts.</p> <p>Aide assessed as not competent in usingDME, including the Hoyer lift and/or stander lift, or any other skills the aideis to perform, will be placed on Active Restricted status and will be removedfrom assigned schedule until competency reassessed by the RN. Once competency re-assessed by the RN,</p>	

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	<p>hospital, or other healthcare facility. 3.3. Competency assessment is conducted initially during orientation and annually thereafter. ... 3.3.3. No Direct Care Staff may independently provide care to a patient without having previously been deemed as competent to provide the care for the assigned patient. ... 3.4. An established protocol will be used as a guideline for competency assessment. 3.4.1. The reference for the protocols is the most current version of the Visiting Nurses of America Nursing Procedure Manual. ... 3.5.1.1. For each competency assessment which requires the evaluation of the employee's management or use of a piece of equipment or supplies and the specific piece of equipment or supplies is not available in the office, the DOCS or clinical designee may arrange for the equipment validation component of the competency assessment to be completed in an alternate location. ... 5.4.1.3. The following competencies must be evaluated while the aide is performing the task with a person: ... 5.4.1.3.9. Safe transfer techniques and ambulation. ... 5.5.1. Annual competency assessment must be completed at least annually (onetime per calendar year). Additional competencies may be required for change in patient assignment, performance issues, new technology or other</p>		<p>andaide assessed to be competent in using DME, including the Hoyer lift and/orstander lift, or any other skills the aide is to perform, aide will be removedfrom Active Restricted status and placed on Active status and be permitted toprovide direct independent patient care.</p> <p>Ongoing, all HHAs competency assessment formswill be modified to include a checklist of the specific equipment, includingHoyer lift, as well as an area to write in other specific equipment, i.e.stander lift, slide board, etc, used during competency assessment. RN evaluatorand aide will acknowledge, on the competency assessment form, the use of a liveperson during competency assessments. DOCS or designee will review all initial andannual/ongoing aide competency assessment forms to ensure proper comps, includingthe Hoyer, stander lift and any other specific DME comp, have been completed bythe RN on a live person and that the specific equipment is properly documentedprior to aide providing direct independent patient care. DOCS or designee will initial bottom cornerof competency assessment form to indicate this review was completed. Aides will be placed on Active RestrictedStatus and will not be permitted to provide direct independent patient careuntil this review is completed and</p>	

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	<p>indications at the discretion of the DOCS or clinical designee."</p> <p>8. The agency's policy titled "Patient/Client Scheduling," # MD-CL-016.4, effective 9/1/14, states, "3.3. Patient/client scheduling requires communication ... The scheduler may not assign an employee to a patient/client that has not been deemed as competent to provide care to a particular patient/client without approval from the DOCS or clinical designee. This approval is documented and maintained in the medical record."</p>		<p>documented. Once the review is complete and documented, the aide will be removed from Active Restricted Status and placed on Active Status and be permitted to provide direct independent patient care. No HHA may independently provide care to a patient without having previously been deemed competent, by an RN, to provide the care for the assigned patient.</p> <p>All office staff will be educated on the appropriate competency assessment process, including the existing policy requirement that all unskilled workers shall be assessed by an RN using a live person and that the specific equipment must be recorded when performing a competency assessment, by the DOCS and AM/designee. This education will be documented and maintained in the QI binder. Each staff member will sign an acknowledgement form to indicate receipt and understanding of new process.</p> <p>To ensure this alleged deficiency does not recur, during quarterly self-audits, the DOCS or designee will review 10 or 10% of total patient records, whichever is greater as well as 10 or 10% of total personnel files whichever is greater. This review will include an equal mix of Skilled and Unskilled clinical records as well as a mix of skilled and</p>	

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G000224	<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. Based on clinical record review, and policy review, the agency failed to ensure the registered nurse prepared the home health aide (HHA) assignment sheets according to physician orders for 1 of 5 records reviewed of patients receiving HHA services, creating the potential to affect all the agency's patients who receive HHA services. (# 6)</p>	G000224	<p>unskilled worker files, to ensure HHA competency Assessments, including Hoyer, stander lift and other specific DME comps, as well as all other skills the aide will perform, were completed by an RN on a live person, and that the specific equipment used in the assessment is properly documented.</p> <p>The Administrator/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur. Completion date: 1/27/15</p> <p>Response to G 224 Assignment and Duties of the Home Health Aide Internal Clinical Staff will be educated on Company Policy titled "Home Health Aide Plan of Care" to include the requirement for the registered nurse (RN) to prepare the home health aide (HHA) assignment sheets according to physician orders. This education will be completed by 2/13/15 and documentation of the education to</p>	02/20/2015

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	<p>Findings include</p> <p>1. Clinical record #6, SOC 3/13/12, contained a POC dated 8/29-10/27/14 21-35 hours a week for 60 days and skilled nurse monthly and as needed for Foley change for 60 days. HHA to monitor blood pressure daily and in a sitting position and record, bed bath daily in morning and per request, hair care in morning, assist with mouth care daily and per request, skin care daily after bath and per request, dressing in morning, before bed and per request, shave per request, nail care weekly, denture care per request, incontinent care immediately upon soiling, peri-care after each bowel movement, peri care and clean around Foley catheter, transfer client from bed to chair using Hoyer lift each morning, assist with repositioning, transfer from chair to be each evening via Hoyer lift, ROM active/passive each shift all extremities and light housekeeping each shift.</p> <p>2. The HHA care plan dated 8/26/14 stated "total bed bath, assist with shaving, transfer assist, assist in/out of bed, reposition, ROM active and passive, catheter care, empty catch bag, incontinence/peri care, last bowel movement, hair care/shampoo, mouth care, skin care, nail care, prepare meal,</p>		<p>bemaintained in the QI binder. 100% of HHA patient's clinical records, including clinical record for patient #6, will be reviewed to ensure that the HHA Care Plans include the Physician Orders as indicated on the 485 Plan of Care. This review will be completed by 2/13/15 and all HHA Care Plans, including HHA Care Plan for patient #6, will be updated according to Physician Orders by 2/20/15. To ensure this alleged deficiency does not recur, during the quarterly self-audit, the DOCS or designee will review 10 or 10% of total patient records, whichever is greater and will include an equal mix of Skilled and Unskilled clinical records, to ensure the HHA Care Plans include the Physician Orders as indicated on the 485 Plan of Care for the unskilled clinical records. The Accounts Manager/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur. Completion Date: 2/20/15</p>	

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	<p>serve meal, encourage fluids, housekeeping." All tasks assigned were noted by asterisk in reference to "Check box under comments if patient/caregiver is functionally and cognitively able to make the choice." The box marked Vital Signs was checked NO and the special instructions section stated "1. Vital signs upon client or supervisor request." The registered nurse failed to assign vitals per physician order.</p> <p>The Aide Weekly Notes dated 9/1, 9/2, 9/3, 9/4, 9/5, 9/8, 9/9, 9/10, 9/11/14 failed to evidence the HHA performed blood pressure daily.</p> <p>3. The agency's policy titled "Home Health Aide Plan of Care," # HH-CL-008.5, effective 4/7/14, states, "3.1. The Home Health Aide Plan of Care (HHA POC) will be individualized to the specific patient and will include at least: ... 3.1.1. Type of services/procedures to be provided, ... 3.1.7. Activities permitted, 3.1.8. Nutritional requirement, if relevant, 3.1.9. Specific procedure(s) to be performed, including amount, frequency and duration, 3.1.10. Safety measure, including specific equipment.</p>						

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G000225	<p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. Based on clinical record review, and policy review, the agency failed to ensure the Home Health Aides (HHA) followed the Aide Care Plans ordered by the physicians for 2 of 10 clinical records reviewed of patients receiving HHA services, creating the potential to affect all the agency's 73 patients receiving HHA services. (#2 and 6)</p> <p>Findings include</p> <p>1. Clinical record #2, start of care (SOC) 5/7/14, contained a plan of care (POC) dated 1/2-3/2/15 with orders for HHA 34-56 hours a week for 60 days. HHA to complete bed bath every other day and at client's request, assist client with mouth care daily and at request, perform skin care daily following bed bath and at request, assist with dressing daily, shampoo hair 2-3 times weekly and at</p>	G000225	<p>Response to G 225 All home health aides (HHA), including HHAs assigned topatients of clinical records #2 and #6, will receive in-service education on Followingthe Plan of Care. This education will bemailed to the HHAs via an in-service education mailer by 2/6/15. This education will be documented andmaintained in the QI binder. Beginning 2/16/15, 100% of HHA notes will be reviewed weeklyduring the Focused Documentation Review process, to ensure that HHAs arefollowing the plan of care. This reviewwill be documented and maintained in the Documentation Review binder. As part of the Documentation Review process,any aide identified as not following the Aide Care Plan will be contacted andre-education will be provided. Thisre-education will be documented in the Worker logging. To ensure this alleged deficiency</p>	02/20/2015

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	<p>request, shave client at request, clean and file nails at request, assist with all transfers daily using slide board, assist with ambulation at request, assist into and out of bed daily at request, reposition client daily and at request, perform active and passive ROM daily and at request, apply heel boots while client is in bed and at request, light housekeeping each shift, assist client meal preparation and serve daily and at request, encourage fluids every shift, complete incontinent care immediately up on soiling, and peri-care after each bowel movement.</p> <p>A. The HHA care plan dated 12/29/14 stated "total bed bath every other day, transfer assist, assist in and out of bed, assist with shaving, ambulation assist, reposition, range of motion (ROM) active and passive, incontinence/peri care, incontinent brief, last bowel movement, hair care/shampoo 2-3 times a week, nail care, assist with dressing, prepare meal, serve meal, encourage fluids, laundry, clean bedroom, clean bathroom, change/make be, clean kitchen, vacuum/sweep." All tasks assigned were noted by asterisk in reference to "Check box under comments if patient/caregiver is functionally and cognitively able to make the choice."</p> <p>B. The Aide Weekly Note dated</p>		<p>does not recur, during the quarterly self-audit, the DOCS or designee will review 10 or 10% of total patient records, whichever is greater and will include and equal mix of Skilled and Unskilled clinical records, to ensure the HHAs are following the Aide Care Plans.</p> <p>The Accounts Manager/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur.</p> <p>Completion Date: 2/20/15</p>	

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	<p>1/10/15 failed to evidence the HHA performed: transfer assist, and assist in/out of bed.</p> <p>C. The Aide Weekly Note dated 1/5, 1/6, 1/7, 1/8, and 1/9/15 evening shift, failed to evidence the HHA performed total bed bath, ambulation assist on 1/5 and 1/9, ROM passive and active 1/5, and ROM active on 1/9/15, mouth care on 1/5 and 1/9, and assist with dressing on 1/9/15. The aide note failed to evidence the patient refused to have these services provided.</p> <p>D. The Aide Weekly Note dated 1/5, 1/6, 1/7, 1/8, and 1/9/15 morning shift, failed to evidence the HHA performed total bed bath and ambulation assist on all 5 days. The note evidenced the HHA provided a partial bath on 1/5 and 1/9/15 instead of total bed bath. The note failed to evidence the patient requested a partial bath.</p> <p>2. Clinical record #6, SOC 3/13/12, contained a POC dated 8/29-10/27/14 21-35 hours a week for 60 days and skilled nurse monthly and as needed for Foley change for 60 days. HHA to monitor blood pressure daily and in a sitting position and record, bed bath daily in morning and per request, hair care in morning, assist with mouth care daily and</p>			

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	<p>per request, skin care daily after bath and request, dressing in morning, before bed and per request, shave per request, nail care weekly, denture care per request, incontinent care immediately upon soiling, peri-care after each bowel movement, peri care and clean around Foley catheter, transfer client from bed to chair using Hoyer lift each morning, assist with repositioning, transfer from chair to be each evincing via Hoyer lift, ROM active/passive each shift all extremities and light housekeeping each shift.</p> <p>A. The HHA care plan dated 8/26/14 stated "total bed bath, assist with shaving, transfer assist, assist in/out of bed, reposition, ROM active and passive, catheter care, empty catch bag, incontinence/peri care, last bowel movement, hair care/shampoo, mouth care, skin care, nail care, prepare meal, serve meal, encourage fluids, housekeeping." All tasks assigned were noted by asterisk in reference to "Check box under comments if patient/caregiver is functionally and cognitively able to make the choice." The box marked Vital Signs was checked NO and the special instructions section stated "1. Vital signs upon client or supervisor request." The registered nurse failed to assign vitals per physician order.</p>			

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N000000	<p>B. The Aide Weekly Notes dated 9/1, 9/2, 9/3, 9/4, 9/5, 9/8, 9/9, 9/10, 9/11/14 failed to evidence the HHA performed blood pressure daily.</p> <p>3. The agency's policy titled "Home Health Aide Plan of Care," # HH-CL-008.5, effective 4/7/14, states, "3.1. The Home Health Aide Plan of Care (HHA POC) will be individualized to the specific patient and will include at least: ... 3.1.1. Type of services/procedures to be provided, ... 3.1.7. Activities permitted, 3.1.8. Nutritional requirement, if relevant, 3.1.9. Specific procedure(s) to be performed, including amount, frequency and duration, 3.1.10. Safety measure, including specific equipment.</p> <p>This was a state home health licensure survey.</p> <p>Facility #: 003757</p>	N000000	<p>Bysubmitting this POC the agency does not admit the allegations in the surveyreport or that it violated any regulations. The agency is submitting thisPOC in response to its regulatory obligations and commitment to</p>	

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	<p>Medicaid #: 200484160</p> <p>Survey Dates: January 14-23, 2015</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS\</p> <p>Census Service Type:</p> <p>Skilled: 33 Home Health Aide Only: 40 Personal Care Only: 0 Total: 73</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 4, 2015</p>		<p>compliance. Theagency further reserves the right to contrast any alleged findings, conclusionsand deficiencies. The agency intends to request that this POC service asits Credible Allegation of Compliance.</p>	

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NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4646 W JEFFERSON BLVD STE 100 FORT WAYNE, IN 46804
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N000408	<p>410 IAC 17-10-1(d) Licensure Rule 10 Sec. 1(d) Disclosure of ownership and management information must be made to the department at the time of the home health agency's initial request for licensure, for each survey, and at the time of any change in ownership or management. The disclosure must include the names and addresses of the following:</p> <p>(1) All persons having at least five percent (5%) ownership or controlling interest in the home health agency. (2) Each person who is: (A) an officer; (B) a director; (C) a managing agent; or (D) a managing employee; of the home health agency and evidence supporting the qualifications required by this article. (3) The corporation, association, or other company that is responsible for the management of the home health agency. (4) The chief executive officer and the chairman or equivalent position of the governing body of that corporation, association, or other legal entity responsible for the management of the home health agency.</p> <p>Based on document review and interview, the agency failed to ensure changes in management were disclosed to the Indiana State Department of Health (ISDH) for 1 of 1 agency, creating the potential to affect all the agency's patients.</p> <p>Findings include</p>	N000408	Response to N 0408 Please be aware that the notification was originally sent to ISDH on July 30, 2014. However, it was sent in the same package with a notification regarding the appointment of a new Administrator on the Company's PSA license. Based on discussions with personnel at ISDH, Company has since	01/27/2015
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	<p>1. During interview on 1/14 /15 at 9:10 AM, employee A indicated the new alternate administrator was employee B and they began in August or September of 2014 and ISDH was notified.</p> <p>2. On 1/14/15 at 11:55 AM, ISDH indicated via email that they would check the system. As of 1/23/15 at 3:30 PM, ISDH had not received a letter of notification with changes in administrative staff.</p> <p>3. As of 1/23/15 at 3:30 PM, the agency failed to produce a letter of acknowledgement of change in administrative staff from ISDH.</p> <p>4. During interview on 1/23/15 at 3:00 PM, employee B indicated the corporate office said the letter was sent with the personal services agency change in administration and both letters were sent to one person at ISDH.</p>		<p>learned that therelevant notification was likely intercepted by staff responsible for PSAlicensure, and that, per standard ISDH practice, the staff member in questionwould have disregarded the notification rather than forwarding it to the personresponsible for HHA licensure. On 1/23/15, the Company's licensing department re-sentchange in Alternate Administrator notification to ISDH attention BobbieNelson. To ensure this alleged deficiency does not recur, the Administrator/designee will follow up with the Company licensing department on all change inmanagement notifications sent to ISDH. The Administrator/designee will contactthe Company licensing department weekly or until such time that ISDH'sacknowledgment of the change notification is received. Going forward, theCompany licensing department will make sure that all ISDH notifications aresent separately and addressed to the attention of the staff member who isresponsible for the particular license in question. The Accounts Manager/designee or Director of ClinicalServices/designee will be responsible for monitoring these corrective actionsto ensure that the alleged deficiency is corrected and will not recur. Completion Date: 1/27/15.</p>	

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N000446	<p>410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3)</p> <p>Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on employee file review, job description review, policy review, and interview, the administrator failed to ensure all home health aides (HHA) received adequate skills competency prior to being placed in patient homes to provide care for 4 of 8 HHA employee files reviewed, creating the potential to affect all of the agency's 40 HHA only patients. (C, E, F, and L)</p> <p>Findings include</p> <p>1. Employee file C, HHA, date of hire (DOH) 1/5/12, contained a Competency Assessment Worksheet dated 2/15/12. The area labeled "Safe transfer techniques/position and ambulation" failed to evidence which transfer techniques were competency tested and failed to evidence whether the tasks were performed on a pseudo patient or live patient.</p> <p>A. The Aide competency worksheet</p>	N000446	<p>Response to N 0446 HHAs currently assigned to patient #8, including employees E and F, have had competency reassessed on the Hoyer lift using a live person as of 1/22/15. Going forward, all staff assigned to patient #8 will have competency assessed on the Hoyer lift prior to being permitted to perform direct independent patient care. Competencies were documented on the HHAs' competency assessment forms. As further detailed below, competency assessment forms have been updated to specifically indicate Hoyer competency was completed with acknowledgement by the evaluator and the aide that the competency was performed on a live person.</p> <p>HHAs currently assigned to patient #10, including employee F, have had competency assessed on the stander lift as of 1/22/15. Going forward, all staff assigned to patient #10 will have competency assessed on the stander lift prior to being</p>	01/27/2015			

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	<p>dated 11/29/13 contained an area labeled "Safe transfer techniques and ambulation" and area labeled "Assistive Devices." These areas failed to evidence which transfer techniques and assistive devices were competency tested and failed to evidence whether the tasks were performed on a pseudo patient or live patient.</p> <p>B. The file contained an Annual Aide Competency Worksheet dated 1/17/14. The areas are listed as observation, reporting and documentation of patient status and the care or service furnished, basic infection control procedures, and recognizing emergencies and knowledge of emergency procedures. This worksheet failed to evidence the employee was competenced on care providing skills.</p> <p>2. Employee file E, HHA, DOH 4/13/11, contained an Annual Aide Competency Worksheet dated 5/5/14. The areas are listed as observation, reporting and documentation of patient status and the care or service furnished, basic infection control procedures, and recognizing emergencies and knowledge of emergency procedures. This worksheet failed to evidence the employee was competency tested on care providing skills.</p>		<p>permitted to perform direct independent patient care. 100% review of Medical Records and personnel files will be completed to identify all patients with Hoyer lift and stander lift as well as all HHAs assigned to patients with Hoyer lifts and stander lift. Each Aide assigned to a patient with a Hoyer lift and/or stander lift, including employees C, E, F and L, will have competency reassessed on the Hoyer lift and/or stander lift using a live person. Competencies will be documented on the HHAs competency assessment form. Competency assessment form will specifically indicate Hoyer competency and/or stander lift competency was completed with acknowledgement by the evaluator and the aide that the competency was performed on a live person by 1/22/15. Aides not re-comped by 1/22/15, or Aides assessed as not competent in using the Hoyer lift and/or stander lift, will be placed on Active Restricted status and will be removed from assigned schedule until competency completed and documented appropriately. Once competency re-assessed and aide assessed to be competent in using the Hoyer lift and/or stander lift, aide will be removed from Active Restricted status and placed on Active status and be permitted to provide direct independent patient</p>		

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	<p>A. The Aide competency worksheet dated 4/25/13 evidenced the area labeled "Safe transfer techniques and ambulation" but failed to evidence which transfer techniques were competency tested and failed to evidence whether the tasks were performed on a pseudo patient or live patient.</p> <p>B. The Competency Assessment Worksheet dated 3/1/12 contained an area labeled "Safe transfer techniques/positioning and ambulation." This worksheet failed to evidence which transfer techniques were competency tested and failed to evidence whether the tasks were performed on a pseudo patient or live patient.</p> <p>C. The Competency Assessment Worksheet dated 4/25/11 contained an area labeled "Safe transfer." This worksheet failed to evidence which transfer techniques were competency tested and failed to evidence whether the tasks were performed on a pseudo patient or live patient.</p> <p>D. During interview on 1/15/15 at 9:52 AM, employee E indicated they have worked here 5 years and when they did their initial skills competency with the Hoyer lift, they used a mannequin.</p>		<p>care with patients who have Hoyer or Stander lifts. Aide assessed as not competent in using the Hoyer lift and/or stander lift will be placed on Active Restricted status and will be removed from assigned schedule until competency reassessed. Once competency re-assessed and aide assessed to be competent in using the Hoyer lift and/or stander lift, aide will be removed from Active Restricted status and placed on Active status and be permitted to provide direct independent patient care with patients who have Hoyer lifts and/or stander lift.</p> <p>Ongoing, all HHAs competency assessment forms will be modified to include a checklist of the specific equipment, including Hoyer lift, as well as an area to write in other specific equipment, i.e. stander lift, used during competency assessment. Evaluator and aide will acknowledge, on the competency assessment form, the use of a live person during competency assessments that occur in the office skills lab. DOCS or designee will review all initial and annual/ongoing aide competency assessment forms to ensure proper comps, including the Hoyer and stander lift comp, have been completed on a live person and that the specific equipment is properly documented prior to aide providing direct independent patient care. DOCS</p>	

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	<p>3. Employee file F, HHA, DOH 9/10/14, contained an Initial Aide Competency Worksheet dated 9/22/14. The area labeled "Safe transfer techniques and ambulation" failed to evidence which transfer techniques were competency tested and failed to evidence whether the tasks were performed on a pseudo patient or live patient.</p> <p>A. During interview on 1/15/15 at 8:48 AM, employee F indicated they did not have any person in the Hoyer lift when they were competency tested for the skill in the skills lab at Maxim, and they were trained at the patient's home by the other HHA.</p> <p>B. During interview on 1/16/15 at 9:07 AM, employee F indicated they were not asked to be competency tested on the Hoyer again after patient # 8 fell. Employee F indicated they also care for patient # 10 who has a stand up lift, and the previous HHA working at that home trained employee F for everything, including the stand up lift which they had never used prior.</p> <p>C. During home visit observation on 1/21/15 at 12:55 PM, employee S indicated the agency only asked if they have ever used a stander lift before and</p>		<p>or designee will initial bottom corner of competency assessment form to indicate this review was completed. Aides will be placed on Active Restricted Status and will not be permitted to provide direct independent patient care until this review is completed and documented. Once the review is complete and documented, the aide will be removed from Active Restricted Status and placed on Active Status and be permitted to provide direct independent patient care. All office staff will be educated on the appropriate competency assessment process, including the existing policy requirement that all unskilled workers shall be assessed using a live person and that the specific equipment must be recorded when performing a competency assessment, by the DOCS and AM/designee. This education will be documented and maintained in the QI binder. Each staff member will sign an acknowledgement form to indicate receipt and understanding of new process. To ensure this alleged deficiency does not recur, during quarterly self-audits, the DOCS or designee will review 10 or 10% of total patient records, whichever is greater as well as 10 or 10% of total personnel files whichever is greater. This review will include an equal mix of Skilled and Unskilled clinical records as well as a mix of skilled and unskilled</p>				

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	<p>told them to watch employee F.</p> <p>D. During home visit observation on 1/21/15 at 1:00 PM, patient # 10 indicated the agency has never sent anyone out (nurse) to competency test any of the HHAs on the stander lift, the patient has had to orient the HHAs to the lift themselves, and the agency has it listed as a Hoyer lift on the plan of care.</p> <p>4. Employee file L, HHA, DOH 7/17/14, contained an Initial Aide Competency Worksheet dated 7/29/14. The area labeled "Safe transfer techniques and ambulation" failed to evidence which transfer techniques were competency tested and failed to evidence whether the tasks were performed on a pseudo patient or live patient.</p> <p>5. During interview on 1/14/15 at 2:05 PM, employee A indicated Maxim does use a pseudo patient for skills competency and the "safe transfer techniques and ambulation" section includes Hoyer lift, slide board, and other transfers.</p> <p>6. During interview on 1/14/15 at 2:15 PM, employee I indicated they typically do not do skill competencies in the patients' homes unless there is something the agency does not have in the lab.</p>		<p>worker files, to ensure HHA competency Assessments, includingHoyer and stander lift comps, were completed and that the specific equipmentused in the assessment is properly documented as well as to ensure thatassigned aides were competency assessed on the relevant transfer equipment. The Accounts Manager/designee orDirector of Clinical Services/designee will be responsible for monitoring thesecorrective actions to ensure that the alleged deficiency is corrected and willnot recur. Completion date: 1/27/15</p>				

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	<p>7. The agency's job description titled "Director of Clinical Services (DOCS)," effective 3/5/13, states, "Essential Duties and Responsibilities: Responsible for maintaining compliance with applicable local, state, and federal regulations, Company policies and procedures, and accrediting agency requirements. ... Manages and provides to all clinical personnel ongoing education, in-service training programs, and competency evaluations to enhance quality patient care.</p> <p>8. The agency's policy titled "Competency Assessment-Direct Care Staff," # MD-HR-008.6, effective 1/5/15, states, "3.1. The Company is responsible for the design and implementation of its competency assessment program. The Administrative Officer (AO), or designee, is responsible for the ongoing adherence to the competency assessment program for assigned office(s). 3.2. The competence of the Direct Care Staff is accomplished through clinical observation, skills lab demonstration, supervisory visits, knowledge-based tests, situational analysis/case studies, and self-assessment. An employee self-skills assessment tool alone is not sufficient to evaluate competency. ... 3.2.2. For unskilled staff (HHA, CNA, etc.) the</p>			

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	<p>competency assessment must be performed on a person. The use of a mannequin for unskilled staff skills competency assessment is not acceptable. The evaluation may occur in the patient/client's residence, the office skills laboratory, a skilled nursing facility, hospital, or other healthcare facility. 3.3. Competency assessment is conducted initially during orientation and annually thereafter. ... 3.3.3. No Direct Care Staff may independently provide care to a patient without having previously been deemed as competent to provide the care for the assigned patient. ... 3.4. An established protocol will be used as a guideline for competency assessment. 3.4.1. The reference for the protocols is the most current version of the Visiting Nurses of America Nursing Procedure Manual. ... 3.5.1.1. For each competency assessment which requires the evaluation of the employee's management or use of a piece of equipment or supplies and the specific piece of equipment or supplies is not available in the office, the DOCS or clinical designee may arrange for the equipment validation component of the competency assessment to be completed in an alternate location. ... 5.4.1.3. The following competencies must be evaluated while the aide is performing the task with a person: ... 5.4.1.3.9.</p>			

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	<p>Safe transfer techniques and ambulation. ... 5.5.1. Annual competency assessment must be completed at least annually (onetime per calendar year). Additional competencies may be required for change in patient assignment, performance issues, new technology or other indications at the discretion of the DOCS or clinical designee."</p> <p>9. The agency's policy titled "Patient/Client Scheduling," # MD-CL-016.4, effective 9/1/14, states, "3.3. Patient/client scheduling requires communication between the Director of Clinical Services (DOCS) or clinical designee and the assigned scheduler. The DOCS or clinical designee is responsible for identifying the appropriate and competent Direct Care Staff eligible for a particular patient/client assignment and informing the scheduler of particular patient/client requirements. The scheduler is then responsible for selecting qualified Direct Care Staff from the pool of appropriate and competent Direct Care Staff. The scheduler may not assign an employee to a patient/client that has not been deemed as competent to provide care to a particular patient/client without approval from the DOCS or clinical designee. This approval is documented and maintained in the medical record. ... 5.5. Following the initial visit, the</p>			

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N000470	<p>DOCS or clinical designee identifies any client specific needs or clinical competencies required for assignment and communicate these to the scheduler.</p> <p>5.1.1. Client specific needs may include but not be limited to the following: ...</p> <p>5.1.1.2. Skill, education, training and availability of direct Care Staff."</p> <p>10. The agency's policy titled "Home Health Certification and Plan(s) of Care," # HH-CL-007.6, effective 11/10/14, states "Policy ... 3.7. ... No clinical assignment will be made unless the Direct Care Staff has had competencies assessed as required for the specific assignment. These competencies are based on the same VNAA procedures. 4. Definitions 4.1. Direct Care Staff: Those individuals that provide or direct care to the patient's in his/her home or alternate care setting."</p> <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. Based on observation, policy review, document review, and interview, the agency failed to ensure staff followed infection control policies and procedures for 4 of 5 home visits, creating the</p>	N000470	<p>Response to N 0470 We currently have in place infection control policies and procedures that conform to the federal requirements. All skilled and</p>	02/20/2015

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	<p>potential to affect all the agency's patients. (#1, 7, 8, and 10)</p> <p>Findings include</p> <p>1. During home visit observation on 1/20/15 at 1:10 PM, employee E, a home health aide, failed to wash hands for longer than 10 seconds after providing care to patient # 8.</p> <p>2. During home visit observation on 1/21/15 at 8:30 AM, employee N placed nursing bag directly on patient's floor without a barrier.</p> <p>A. At 8:55 AM, employee Q donned gloves, picked up urostomy drainage container to put vinegar into it, went to bathroom to get vinegar bottle and saw there was not enough vinegar in it, so went to kitchen cupboard beside stove to get big bottle of vinegar. Employee Q failed to remove gloves and wash hands or use hand gel prior to touching cupboard in kitchen beside stove.</p> <p>B. At 9:00 AM, employee Q removed gloves and washed hands at kitchen sink and used patient's dish towel to dry hands. Employee Q failed to dry hands on a clean, dry paper towel.</p> <p>3. During home visit observation on</p>		<p>unskilledclinical staff, including Direct Caregivers and Internal Clinical Staff as wellas employees N, Q, F, R and A and direct caregivers assigned to patient's #1,7, 8 and 10, will be re-educated on Infection Control Policies and Procedures,including Company Policy titled "Hand Hygiene". Acknowledgment of re-educationcompletion will be signed by direct caregivers and kept in the Personnel File. All Skilled staff, including Direct Caregiversand Internal Clinical Staff as well as employees N, R and A, will be educatedon Bag Technique per Company SOP titled "Bag Technique" and VNAA guidelinetitled "Infection Control-Bag Technique". This education will be mailed to the Direct Caregivers via an in-serviceeducation mailer by 2/6/15. Thisin-service education will be provided to the internal clinical staff by 2/5/15.This education will be documented and maintained in the QI binder. Beginning 2/16/15, during Supervisory Visits, the ClinicalSupervisor will observe the direct caregiver performing Infection Controlprocedures during Supervisory Visits when a direct caregiver is present. This observation will be documented on theSupervisory Visit note. To ensure this alleged deficiency does not recur, during thequarterly</p>				

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	<p>1/21/15 at 12:30 PM, employee F was observed shaving the legs of patient # 10. Employee F placed socks on patient's feet and then proceeded to get a drink for the patient. Employee F failed to wash hands after placing socks on patient.</p> <p>A. Employee F took trash from patient's beside chair to big trash can in garage, then proceeded to get the stander lift ready for patient use. Employee F failed to wash hands after taking trash to garage trash can.</p> <p>B. Employee F provided range of motion to patient's bilateral legs, then proceeded to put own hair into a pony tail and pull the stander lift over to the chair. Employee F failed to wash hands after providing range of motion to patient's legs and failed to wash hands after placing own hair in ponytail.</p> <p>4. During home visit observation on 1/22/15 at 2:00 PM, employee R placed nursing bag directly on dining room chair and failed to use a barrier.</p> <p>5. During interview on 1/23/15 at 1:54 PM, employee A indicated they did not recall a bag technique policy but would expect the staff to use and follow it.</p> <p>6. During interview on 1/23/15 at 2:06</p>		<p>self-audit, the DOCS or designee will review the Supervisory visitnotes on 10 or 10% of total patient records, whichever is greater, to ensurethe Clinical Supervisors are observing Infection control procedures duringSupervisory Visits when direct caregiver is present and documenting thisobservation on the Supervisory Visit note. Additionally, during the quarterly self-audit, the DOCS or clinical designeewill conduct a minimum of 5 patient observation visits and will observeinfection control procedures completed by direct caregiver during this visit.</p> <p>The Accounts Manager/designee or Director of Clinical Services/designeewill be responsible for monitoring these corrective actions to ensure that thealleged deficiency is corrected and will not recur.</p> <p>Completion date: 2/20/15</p>	

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	<p>PM, employee B indicated the agency does have a bag technique policy, staff should be following it, and it is available on the company's computer learning portal. Employee B also indicated the agency follows Visiting Nurse Associations of America (VNAA) guidelines for clinical reference.</p> <p>7. During interview on 1/23/15 at 2:08 PM, employee B indicated staff can sing the ABC's to be sure washing hands long enough.</p> <p>8. The agency's policy titled "Hand Hygiene," # MD-ICS-005.3, effective 9/1/14, states, "3.1. Personnel providing care or services in the home setting will regularly wash their hands, per the most recently published CDC regulations and guidelines for hand hygiene in health care settings. ... 3.3. When hands are not visibly soiled, they should be decontaminated using an alcohol-based hand rub. ... 4.1.4. Hand decontamination using an alcohol-based hand rub should be performed: 4.1.4.1. Before having direct contact with patients/clients. ... 4.1.4.3. After contact with a patient's/client intact skin. ... 4.1.4.6. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. 4.1.4.7. After removing gloves. ...</p>			

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	<p>4.1.6. Hand Washing with Soap and Water, 4.1.6.1. Equipment, 4.1.6.1.1. Paper towels, 4.1.6.1.2. Liquid soap, 4.1.6.2. Wet hands and apply the soap, and rub hands together vigorously; ... 4.1.6.3. Wash hands for at least 15 seconds covering all surfaces of the hands and fingers. 4.1.6.4. Rinse with water and dry the hands with a disposable towel from the fingers toward the forearm."</p> <p>9. The agency's policy titled "Bag Technique,"# SOP-MD-ICS-001a, effective 9/1/14, states, "1.0 Adhere to Standard Precautions, 2.0 Select a clean flat surface or a doorknob for the bag, 3.0 Place a barrier on flat surface before setting bag down if desired. ... Considerations: ... 2. As homes differ greatly, Direct Care Staff will need to use judgment in selecting an appropriate work area. Considerations include: cleanliness of home, adequate lighting, low traffic area, away from direct currents from windows, heat or air conditioning vents, safe area for bag away from pets and children."</p> <p>10. The VNAA guidelines document for Infection Control-BAG TECHNIQUE, Section 07.01, last updated 9/2012, states, "Considerations: 1. The purpose of bag technique is to reduce the risk of</p>			

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N000514	<p>cross-infection between patients via the visit bag and the supplies it contains. 2. The visit bag needs to be kept clean by: ... d. Placing the bag in a "clean" area of home: i. Appropriate areas include placing on a clean hard surface or a paper towel, or hanging on the back of a chair or door knob. ii. Do not contaminate the home with your bag, e.g., do not put on patient's bed, or place wheels of roller bag on patient's furniture."</p> <p>410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint. Based on complaint log review, policy review, and interview, the agency failed to ensure all complaints or concerns regarding care were documented and investigated for 1 of 1 complaint log</p>	N000514	<p>Response to N 0514 The substantive issues raised by the Patients #8 and #10 have been addressed. Employee D was suspending pending investigation on 01-16-2015, based</p>	02/18/2015

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	<p>review, creating the potential to affect all the agency's patients. (# 8 and 10)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During home visit observation on 1/20/15 at 12:50 PM, patient #8 indicated their family member told agency employee H, several times, that employee C needed to be re-trained on the Hoyer lift but that never happened. 2. The agency complaint log failed to evidence any complaints about home health aides (HHA) needing to be re-trained. 3. During interview on 1/16/15 at 11:20 AM, employee H indicated these complaints/concerns go under worker loggings, but it is not saved anywhere. 4. During interview on 1/16/15 at 1:50 PM, employee A, administrator, indicated they have not heard of any requests, complaints, or concerns of HHA need re-training. 5. During interview on 1/16/15 at 1:10 PM, employee A indicated patient # 10 said okay for a home visit next week, but the patient was planning on also telling surveyor about employee D, a HHA who stole from the patient. Employee A 		<p>on the allegation of theft from Patient #10. Patient #10's services have been consistently staffed since 1-18-15. As further detailed under discussion of (G134/N446), all Aides, including employee C, have received updated competency assessments for all patient transfer techniques. The grievance log will be reviewed to ensure that all documented grievances, including those from patient's #8 and #10 have been investigated per Company policy. This review will be completed by the DOCS and AM/designee by 2/13/15. All internal office staff will be re-educated on the Company Policies titled "Grievance and Complaints" and "Patient/Client Rights and Responsibilities". An office process will be developed, based on the current Grievance Policy, in order to ensure that all complaints or concerns regarding care are documented and investigated, as well as to avoid inconsistent/lack of response and follow up when the office is notified of concerns with staff competency related to performance tasks/skills in the home setting as well as when a request is made by family member, patient or caregiver for additional staff training on a skill/task/DME. This process will include steps to take when a call is received by non-clinical staff as well as steps for clinical designee to take when following up on the reported concern and/or request. All internal office staff will be educated on the</p>				

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	<p>indicated the police already investigated and that employee is in jail.</p> <p>A. The agency's complaint log failed to evidence a complaint about employee D having stolen anything from patient # 10. The only complaint evidenced about employee D was dated 10/22/14 and involved the employee eating patient # 8's food, and was resolved on 11/20/14.</p> <p>B. On 1/21/15 at 10:25 AM, surveyor called patient #10. Patient #10 indicated they did not cancel the visit, they just did not want employee K at the home visit also as they had things they wanted to tell the surveyor without the employee around for fear of retaliation. Patient # 10 indicated the weekend before Christmas, they did not have any help for 4 days straight and the following week they had 5 different aides, and the aides stole over \$10,000.00 worth of jewelry from them. Patient indicated some of the jewelry was located at a pawn shop. Patient indicated they had called the agency to ask for the phone number to Indiana State Department of Health (ISDH) because they wanted to file a complaint about being left without help for 4 days straight, and the agency told the patient to just call the compliance line for Maxim.</p>		<p>new process, including existing Company Grievance policy and Patient/Client Rights and Responsibilities policy, by 2/18/15 by the DOCS/AM/designee. This education will be documented and maintained in the QI binder. Each internal staff member will sign an acknowledgement form to indicate receipt and understanding of the new process. Additionally, all employees are required to take the Company's Annual Compliance training which includes education specific to Patient Rights. Weekly, the DOCS and AM/designee will review the grievance log to ensure that all complaints and concerns have been documented and are being investigated per Company policy. This weekly review will be documented on a Grievance Trackers spreadsheet. This weekly review began 2/6/15 and will continue on-going. To ensure this alleged deficiency does not recur, the DOCS or designee will review the Grievance binder and Grievance Tracker spreadsheet during quarterly self-audits to ensure that all complaints or concerns, including all reports of concerns with staff competency when performing a task/skill or request for additional staff training on a skill/task/DME are addressed by clinical designee and all required follow up has been completed. The Accounts Manager/designee or Director of Clinical Services/designee</p>				

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	<p>C. Clinical record # 10 evidenced a communication note dated 12/18/14 between the patient's case manager at Real Services and the agency, and stated, "Spoke with [name of case manager] with Real Services in regards to [patient's] staff. [case manager] stated that [patient] said they did not have staff for four weeks and [patient] would like to report an incident report to the state. I ran through the days that we had staff for [patient] since the HHA was pulled for legal concerns. [Case manager] said there is no need to write an incident report since [patient] has been staffed for the most part." This documentation was entered by employee J at 4:05 PM.</p> <p>6. The agency's policy titled "Grievances and Complaints," # MD-ERR-005.4, effective 9/1/14, states, "5.2. Grievances may be reported via the following methods: ... 5.2.2. Directly to the office providing the care and/or service. ... 5.3. Grievances received from the patient/client and/or family/caregiver will be documented on a Patient Grievance form. 5.3.1. Each employee is responsible for immediate response to reported grievances and should attempt to provide resolution where applicable. 5.3.2. The AM, Director of Clinical Services (DOCS) or designee is responsible to contact the person who</p>		<p>will be responsible for monitoring these corrective actionsto ensure that the alleged deficiency is corrected and will not recur. Completion Date: 2/18/15</p>				

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	<p>filed the grievance and attempt to resolve the issue. Once resolution is achieved, the DOCS, clinical designee or AM will contact and inform the person of the resolution and ensure satisfaction.</p> <p>5.3.2.1. The grievance investigation shall begin within 2 business days of receipt.</p> <p>5.3.2.2. The DOCS or AM is responsible for directing the investigation and follow up, and for ensuring resolution. ... 5.4.1. The documentation shall be maintained in the Grievance Binder. ... 5.6 The DOCS, clinical designee and AM are responsible for ensuring that all employees are aware of the process for receiving, reporting, resolving (to the best of their abilities) and documenting any/all patient/client and/or family grievances."</p> <p>7. The agency's policy titled "Patient/Client Rights and Responsibilities," # MD-ERR-001.5, effective 9/1/14, states, "3.2. A patient/client may designate someone to act as his/her representative. This representative, on behalf of the patient/client, may exercise any of the rights provided by the policies and procedures. ... 5.2. Home care patients/clients have the right to: ... 5.2.16. Voice grievances/complaints regarding treatment or care that is or fails to be furnished, lack of respect of property, or recommended changes in</p>			

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N000522	<p>policy, staff, or service/care without restraint, interference, coercion, discrimination, or reprisal and to have those grievances/complaints investigated."</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure the frequencies and hours of services ordered on the plan of care (POC) were met for 3 of 10 clinical records reviewed, creating the potential to affect all the agency's patients. (# 1, 5, and 10)</p> <p>Findings include</p> <p>1. Clinical record #1, start of care (SOC) date 12/30/13, contained a POC dated 12/25/14-2/22/15 with orders for skilled nurse (SN) 1 time a week for urostomy change and as needed for 60 days and home health aide (HHA) 17-28 hours a week for 60 days.</p>	N000522	<p>Response to N 0522 All internal office staff, including employee J, will receive re-education on Company SOP titled "Missed Shift/Visit" by 2/20/15. This education will be documented and maintained in the QI binder. Clinical record #1: Weekly nursing visits staffed consistently since 1/29/15. Clinical record #5: Patient transferred to another home health provider and was discharged on 1/26/15. Clinical record #10: Patient has been staffed consistently since 1/18/15. A new office process has been developed which will include the recruiters calling all primary and secondary direct caregivers to check availability to meet the staffing requirement per the plan of care. If</p>	02/20/2015

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	<p>A. The clinical record failed to evidence a SN visit was conducted on 1/1/15 and 1/15/15.</p> <p>B. During interview on 1/21/15 at 3:30 PM, employee B indicated there were missed visits on this patient.</p> <p>C. The Communication Noted dated 1/20/15 at 9:46 AM, evidenced employee J called the patient and the nurse about the missed visits and the client said parent was helping out and they have been calling the nurse directly to cancel the visits, and the nurse said patient did notify them.</p> <p>D. During interview on 1/21/15 at 4:20 PM, employee A indicated best practice for notifying physician of missed visits is within 14 days.</p> <p>2. Clinical record # 5, SOC date 7/22/13, contained a POC dated 11/14/14-1/12/15 with orders for SN 50-84 hours per week for 60 days, client eligible for respite SN services not to exceed 720 hour for authorized dates.</p> <p>A. The record failed to evidence SN services were provided on 11/23/14 for 12 hours, 11/25/14 for 6 hours, and 11/27/14 for 12 hours. The Missed Visit form dated 12/10/14 evidenced the</p>		<p>theprimary and secondary direct caregivers are unavailable, qualified staff willbe reviewed as an option with the patient & primary caregiver; ifacceptable, the new staff will receive a patient specific orientation from theMaxim Clinical Supervisor/clinical designee prior to working the shift. Measures have been taken by the Administratorto ensure that appropriate clinical staff in the office is made aware of anyfailures to cover a shift, gaps in coverage, to ensure that our efforts arecoordinated effectively and support the plan of care. Measures have been taken by the Administrator to ensure acontractual agreement with the Maxim Staffing Solution to assist with providinga qualified caregiver in the event an open shift cannot be filled by the HomeHealth Agency's own employee pool. If no staff is available, the patient,primary caregiver, physician and patient's case manager are notified andalternate forms of care are discussed. All communications will be recorded in the system of record. If it is identified that staffingunavailability will not be intermittent but long term, then there will beincreased recruitment efforts. If these increased efforts to staff the patient perphysician ordered frequency are not effective, then we will refer to thedischarge policy because we will have met one of the</p>				

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	<p>reason being "Unable to backfill registered nurse (RN) / licensed practical nurse(LPN)."</p> <p>B. During interview on 1/23/15 at 8:50 AM, employee B indicated unable to backfill means they did not have an option to cover the shifts due to call offs by staff, unable to find staff, and/or other various reasons.</p> <p>C. The record failed to evidence any loggings of missed visit communication with patient or primary caregiver for the missed dates.</p> <p>3. Clinical record # 10, SOC date 9/15/14, contained a POC dated 11/14/14-1/12/15 with orders for HHA 25-42 hours per week for 60 days.</p> <p>A. The record failed to evidence 25 hours were provided the weeks of 12/14-12/20/14 and 12/21-12/27/14.</p> <p>B. The Missed Visit form dated 12/19/14 for the HHA shift stated the reason being "Unable to backfill Aide," and was signed on 1/14/15 by employee J. This form states Notification was to physician, Director of Clinical Services (DOCS), Case Manager, and Family and/or Caregiver, as evidenced by check marks in the boxes noted YES.</p>		<p>criteria for dischargethat states available personnel are adequate for the continuing needs of theclient and notify our legal representative for guidance.</p> <p>The Administrator/designee will educate all Internal Officestaff on new office process by 2/20/15. This education will be documented and maintained in the QI binder.</p> <p>The Administrator/designee or Director of ClinicalServices/designee will assume responsibility to ensure adherence to staffingper the plan of care, discharge policy, and contacting physicians and casemanagers to assist with alternative staffing plans to meet the needs of thepatient. During quarterly self- audits, the Administrator/designee will review10 or 10% of total patient records, whichever is greater, to ensure thatstaffing was provided per the plan of care as well as to ensure thatpatient/caregiver, physician and case manager were notified of missed shifts.</p> <p>The Administrator/designee will be responsible formonitoring these corrective actions to ensure that the alleged deficiency iscorrected and will not recur.</p> <p>Completion date: 2/20/15</p>				

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	<p>C. The Missed Visit form dated 12/22/14 and 12/25/14 for the HHA shift stated the reason being "Unable to backfill Aide," and was signed on 1/14/15 by employee J. This form states Notification was to physician, DOCS, Case Manager, and Family and/or Caregiver, as evidenced by check marks in the boxes noted YES.</p> <p>D. The communication note dated 1/21/15 at 1:40 PM evidenced the physician was not notified of the missed visits for 12/8/14, 12/9/14, 12/19/14, 12/22/14, and 12/25/14 until 1/21/15 and stated, "due to problem with transmitting fax we did not receive a fax communications sheet."</p> <p>E. During interview on 1/22/15 at 9:54 AM, employees A and B indicated a nurse covered the shifts for 1.5 hours on 12/20 and 12/21/14 but the nurse did not document on a HHA sheet, and did not complete any form of documentation.</p> <p>4. The agency's policy titled "Missed Shift/Visit," # SOP-MD-CL-016b, effective 9/1/14, states "Missed shift, A missed shift occurs when the patient's scheduled shift is not completed according to the physician order for the assigned date and hours. ... If at any</p>			

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	<p>time the services provided do not match the physician order (or range of orders) a Missed Shift/Visit Note and notification of the physician is required. The medical record will include all documentation related to the missed shift including alternative care for the patient. ... Process Step 1.0 Notify Office of Potential Missed Shift/Visit, performed by patient and/or direct care staff, as soon as possible, The patient and/or Direct Care Staff should notify the office of a potential missed shift/visit as soon as possible. ... 4.0 Notify patient/Family Caregiver that No Back-up Staff is Available, Performed by AM/Recruiter/DOCS/Designee, Once all options are exhausted, If the office is unable to identify substitute staff, notify the patient/family so that they may assume responsibility for patient care until such time as staff becomes available. ... 5.0 Notify Physician, per DOCS/Clinical Designee Discretion, ... The office may notify the patient's physician and, as applicable, any others that require notification of the missed shift/visit. Note: ... Physician notification is good practice, but is required when the missed shift/visit causes the care to fall below the physician ordered frequency. ... 6.0 ... Cancel the shift/visit in the system of record and updated System to reflect</p>			

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N000524	<p>reason far missed shift/visit. ... 8.0 ... The office will review the physician order to determine whether the missed shift/visit causes the care frequency to fall outside of the shift/visit frequency ordered by the physician. If the care is not within the frequency of shifts/visits ordered by the physician, notify the DOCS or Clinical Designee to evaluate if the program and/or payor source requires an order range/frequency of care/services prescribed. If necessary, the DOCS or clinical designee will need to obtain a supplemental order from the physician."</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (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: (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</p>			

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	<p>referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on clinical record review, observation, policy review, and interview, the agency failed to ensure Plans of Care (POC) included all durable medical equipment (DME) used by the patient for 1 of 5 home visit observations creating the potential to affect all the agency's 73 patients. (# 10)</p> <p>Findings include</p> <p>1. Clinical record # 10, start of care date 9/15/14, contained a POC dated 11/14/14-1/12/15 and a POC dated 1/13-3/13/15 with DME listed as Hoyer lift. During home visit observation on 1/21/15 at 1:00 PM, DME noted in home included a stander lift, called a Get-U-Up lift.</p> <p>A. During home visit observation on 1/21/15 at 1:00 PM, patient # 10 indicated the agency has never sent anyone out (nurse) to competency test any of the home health aides (HHA) on the stander lift, the patient has had to orient the HHAs to the lift themselves, and the agency has it listed as a Hoyer lift on the plan of care.</p> <p>B. The Aide Care Plan dated 9/15/14</p>	N000524	<p>Response to N 0524</p> <p>Internal Clinical Staff will be educated on Company Policy titled "Home Health Certification and Plan of Care" as well as the requirement for the Plan of Care to include all Durable Medical Equipment (DME) used by the patient. This education will be completed by 2/13/15 and documentation of the education will be maintained in the QI binder. Clinical record for patient #10 will be reviewed and Plan of Care updated to include proper Stander Lift. Additionally 100% of medical records will be reviewed, including clinical record for patient #10, to ensure that all Plans of Care include all DME used by the patient by 2/20/15.</p> <p>To ensure this alleged deficiency does not recur, during the quarterly self-audit, the DOCS or designee will review the Plans of Care on 10 or 10% of total patient records, whichever is greater, to ensure the Plan of Care includes all DME used by the patient. Additionally, during the quarterly self-audit, the DOCS or clinical designee will conduct a minimum of 5 patient observation visits and will compare the DME in the home with the DME listed on the Plans of Care to ensure the Plan of Care includes all DME used by the</p>	02/20/2015			

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N000527	<p>and reviewed on 11/11/14 and 1/8/15 stated "Hoyer lift" in the transfer/assist section.</p> <p>C. During interview on 1/21/15 at 2:38 PM, employee A indicated the agency did not know this patient had a different lift and not a Hoyer lift.</p> <p>2. The agency's policy titled "Home Health Certification and Plan(s) of Care," # HH-CL-007.6, effective 11/10/14, states "5.3. The Plan of Care shall include, but not limited to: ... 5.3.4. Listing of equipment and supplies."</p> <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, policy review, and interview, the agency failed to promptly inform the physician of a significant change in condition for 1 of 10 clinical records reviewed, creating the potential to affect all the agency's 73 patients. (# 8)</p> <p>Findings include</p> <p>1. Clinical record # 8, start of care date</p>	N000527	<p>patient.</p> <p>The Accounts Manager/designee or Director of ClinicalServices/designee will be responsible for monitoring these corrective actionsto ensure that the alleged deficiency is corrected and will not recur.</p> <p>Completion Date: 2/20/15</p> <p>Response to N 0527 Internal Clinical Staff will be re-educated on CompanyPolicy titled "Physician Responsibility in Managing Care" to include therequirement to promptly inform the physician of a significant change in patientcondition as well as the requirement to document the physician notification inthe clinical record. This education willbe completed by 2/13/15 and documentation of the education to</p>	02/20/2015

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	<p>5/4/09, contained a plan of care (POC) dated 11/6/14-1/4/15 with a diagnosis of Multiple Sclerosis and orders for home health aide (HHA) 34-56 hours a week times 60 days and skilled nursing (SN) 1 visit three times weekly times 60 days. The POC contained general orders for SN as skilled observation and assessment every shift and as needed for signs of distress including: ... pain and symptom control, ... safety measures, ... mental status. ... signs and symptoms of abnormalities to any of the above are to be reported to the MD.</p> <p>A. The clinical document dated 11/30/14 by employee F, HHA, stated "Around 10 AM I was getting [patient] up had [patient] in Hoyer lift. I pulled the Hoyer lift out and than turned [patient] so feet wouldn't drop on the bed and [patient] fell. When I looked down the hooks were still connected to the blue pad underneath [patient]. So I hurried and unhooked them to check [patient] out. [Patient] wanted me to get [patient] up so I re-hooked the Hoyer lift got [patient] in chair like [patient] requested. I then called Maxim and I told [employee J] everything that happened. [employee J] told me a nurse would call me. When nurse did [nurse] asked what happened I told [nurse] and told [nurse] [patient] had a knot on [patient's] left side head and</p>		<p>be maintained inthe QI binder. Beginning 2/16/15, the DOCS or designee will track allreports of changes in patient condition, including patient #8, to ensure thatrequired follow up, including notification to physician, has occurred per Companypolicy. DOCS or designee will review thechange in condition tracker, as well as applicable patient record, weekly, tovalidate that the physician was promptly notified of any significant change inpatient condition. To ensure this alleged deficiency does not recur, during thequarterly self-audit, the DOCS or designee will review 10 or 10% of totalpatient records, whichever is greater, to ensure that the physician waspromptly notified of any significant changes in patient condition. The Accounts Manager/designee or Director of ClinicalServices/designee will be responsible for monitoring these corrective actionsto ensure that the alleged deficiency is corrected and will not recur. Completion Date: 2/20/15</p>				

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	<p>that [patient's] left shoulder hurt, [nurse] told me to call 911 and to call [nurse] back. So I called 911 and they came to access [patient] and check [patient] vitals, they did and said everything was fine, asked [patient] if [patient] wanted to go in, [patient refused] and then told me to just keep an eye on [patient]. I called the nurse back, told [nurse] what was going on and [nurse] told me also to keep an eye on [patient] and write a clinical documentation."</p> <p>B. During interview on 1/14/15 at 12:05 PM, employee A indicated when a patient falls in the home, the policy is the HHA should call 911 and when the patient is safe then the HHA needs to call the office. If the patient refuses EMS we go do a change in condition visit. On 11/30/14 after the patient fell, the HHA notified the office first, and then 911 was called and the HHA reported the EMS said the patient was stable. Employee A indicated that on 12/1/14 the normal HHA went to care for the patient and called the office saying the patient reported they were not feeling right, so the HHA called 911 and the patient was taken to the emergency room, and found out the patient had a broken shoulder.</p> <p>C. The clinical record failed to evidence the physician was notified of</p>			

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N000541	<p>the patient's fall until 12/9/14. Note: This fall resulted in the patient having a fractured shoulder.</p> <p>D. During interview on 1/15/15 at 12:30 PM, employee A indicated they notified the physician on 12/9/14 of the incident from 11/30/14 as soon as they found out it had not yet been reported.</p> <p>2. During interview on 1/22/15 at 10:30 AM, employees A and B indicated the agency has weekly care coordination meetings to discuss staff issues etc and these are mandatory for everyone, otherwise the communication notes in the computer are to be used for care coordination.</p> <p>3. The agency's policy titled "Physician Responsibility in Managing Care," # MD-CL-005.3, effective 9/1/14, states "4.3. The office's role will include but is not limited to: ... 4.3.1. Timely communication to physician regarding his/her patient to include: 4.3.1.1. Changes in the patient condition. ... 4.3.3. To assist in continuity of care, including ongoing updates, written summaries, and phone consultation."</p> <p>410 IAC 17-14-1(a)(1)(B) Scope of Services</p>			

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	<p>Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse (RN) re-evaluated the patient within 24 hours post fall for 1 of 10 clinical records reviewed, creating the potential to affect all the agency's 73 patients. (# 8)</p> <p>Findings include</p> <p>1. Clinical record # 8, start of care (SOC) date 5/4/09, contained a plan of care (POC) dated 11/6/14-1/4/15 with a diagnosis of Multiple Sclerosis and orders for home health aide (HHA) 34-56 hours a week times 60 days and skilled nursing (SN) 1 visit three times weekly times 60 days. The POC contained general orders for SN as skilled observation and assessment every shift and as needed for signs of distress including: ... pain and symptom control, ... safety measures, ... mental status. ... signs and symptoms of abnormalities to any of the above are to be reported to the MD.</p> <p>A. The clinical documentation dated</p>	N000541	<p>Response to N 0541 Internal Clinical Staff, including employee A (Employee V is no longer employed), will be re-educated on Company Policy titled "Assessment", including the State/Program Specific section for Indiana requirement for a registered nurse (RN) to determine whether the patient's situation requires immediate attention and EMS (911) should be called or whether an assessment is required within 24 hours post fall. This education will be completed by 2/13/15 and will be maintained in the QI binder. Beginning 2/16/15, the office will track all reports of changes in patient condition, including patient #8, to ensure that the required RN follow-up, and/or re-evaluation of the patient, was completed per policy. DOCS or designee will review the change in condition tracker, as well as applicable patient record, weekly, to validate that the required RN follow-up, and/or re-evaluation of the patient, was completed and documented in the patient record. To ensure this alleged deficiency does not recur, during the quarterly</p>	02/20/2015

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	<p>11/30/14 by employee F, HHA, stated "Around 10 AM I was getting [patient] up had [patient] in Hoyer lift. I pulled the Hoyer lift out and than turned [patient] so feet wouldn't drop fro the bed and [patient] fell. When I looked down the hooks were still connected to the blue pad underneath [patient]. So I hurried and unhooked them to check [patient] out. [Patient] wanted me to get [patient] up so I re-hooked the Hoyer lift got [patient] in chair like [patient] requested. I then called Maxim and I told [employee J] everything that happened. [employee J] told me a nurse would call me. When nurse did [nurse] asked what happened I told [nurse] and told [nurse] [patient] had a knot on [patient's] left side head and that [patient's] left shoulder hurt, [nurse] told me to call 911 and to call [nurse] back. So I called 911 and they came to access [patient] and check [patient] vitals, they did and said everything was fine, asked [patient] if [patient] wanted to go in, [patient refused] and then told me to just keep an eye on [patient]. I called the nurse back , told [nurse] what was going on and [nurse] told me also to keep an eye on [patient] and write a clinical documentation."</p> <p>B. During interview on 1/14/15 at 12:05 PM, employee A indicated when a patient falls in the home, the policy is the</p>		<p>self-audit, the DOCS or designee will review 10 or 10% of totalpatient records, whichever is greater, to ensure that required RN follow-up,and/or re-evaluation of the patient, was completed with all changes in patientcondition. The Accounts Manager/designee or Director of ClinicalServices/designee will be responsible for monitoring these corrective actionsto ensure that the alleged deficiency is corrected and will not recur. Completion Date: 2/20/15</p>	

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	<p>HHA should call 911 and when the patient is safe then the HHA needs to call the office. If the patient refuses EMS we go do a change in condition visit. On 11/30/14 after the patient fell, the HHA notified the office first, and then 911 was called and the HHA reported the EMS said the patient was stable. Employee A indicated that on 12/1/14 the normal HHA went to care for the patient and called the office saying the patient reported they were not feeling right, so the HHA called 911 and the patient was taken to the emergency room, and found out the patient had a broken shoulder.</p> <p>C. The On-Call log evidenced on 11/30/14 at 10:19 AM that employee F notified employee V, the clinical supervisor, that the patient had fallen in the Hoyer lift, said patient was back up and ok, and employee V directed HHA to take vital signs and had the clinician on call contact HHA, and employee V followed up with patient's primary care giver (PCG).</p> <p>D. During interview on 1/15/15 at 1:20 PM, employee V indicated they were on call on 11/30/14 and spoke with the HHA (employee F) after patient # 10 fell from the Hoyer lift. Employee V indicated they instructed the HHA to call 911. Employee V indicated policy is the</p>			

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	<p>patient does not get moved before calling 911. Employee V indicated the HHA told them the patient did not lose consciousness and did not hit their head. Employee V indicated the policy for assessing a patient post fall is 911 is to be utilized- if during regular hours, the clinical supervisor needs to assess the patient for a significant change in condition. Employee V indicated the HHA told them the patient was "OK." Employee V indicated this was per paramedic evaluation of what is normal for the patient, and the patient had no signs or symptoms of injury, or complaints, and the EMS deemed the patient to be stable and not needing medical treatment, the patient is alert and oriented, and if the EMS had any questions they can always ask the HHA there. Employee V indicated EMS personnel are of a higher level of care provider than a nurse so we have to trust their judgment, just like we would a physician. Employee V indicated the agency nurse does not have to do anything else unless there are any notable changes like bruising or etcetera. Employee V indicated if transferred to the emergency room and sent home with no issues, the agency does not have to do anything further if the emergency room said the patient was ok, but if the patient was admitted for over 24 hours, then we</p>			

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	<p>would do a resumption of care.</p> <p>Employee V indicated if there are changes within 24 hours of the fall time, then they would go assess the patient, but nobody is going to wait that long if the patient refuses everything else.</p> <p>E. The clinical record failed to evidence the patient was assessed by a nurse until 12/1/14 at 4:30 PM. The care coordination note evidenced the patient returned home from the hospital on 12/1/14 at 2:00 PM.</p> <p>F. During interview on 1/14/15 at 12:08 PM, employee A indicated the nurse did not go assess the patient until 12/1/14 due to the EMS said the patient was stable on 11/30/14. Employee A indicated the policy says the agency has 24 hours to see the patient post fall. Employee A indicated this was an unwitnessed fall and the patient's PCG went to help get the patient back in bed. Employee A indicated the durable medical equipment (DME) company evaluated the Hoyer lift after the fall, but the agency did not receive a copy of that report but was told by the PCG that there was not a problem with the Hoyer lift.</p> <p>2. The agency's policy titled "Assessment," # MD-CL-004.3, effective 9/1/14, states, "6. State/Program Specific</p>			

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N000542	<p>requirement: Indiana For Home Health Aide (HHA) cases the HHA will notify the clinical supervisor immediately for all changes in patient condition such as Falls, Injuries, Pain, or Illness. A Registered Nurse (RN) will make a determination whether the patient's situation requires immediate attention and emergency medical response (911) should be called or whether an assessment is required within 24 hours of agency knowledge."</p> <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 clinical record review, observation, policy review, and interview, the agency failed to ensure the registered nurse updated the Plan of Care (POC) with the correct durable medical equipment (DME) used by the patient for 1 of 5 home visit observations creating</p>	N000542	<p>Response to N 0542 Internal Clinical Staff will be educated on Company Policy titled "Home Health Certification and Plan of Care" as well as the requirement for the Plan of Care to include all Durable Medical Equipment (DME) used by the patient. This education will be</p>	02/20/2015

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	<p>the potential to affect all the agency's 73 patients. (# 10)</p> <p>Findings include</p> <p>1. Clinical record # 10, start of care date 9/15/14, contained a POC dated 11/14/14-1/12/15 and a POC dated 1/13-3/13/15 with DME listed as Hoyer lift. During home visit observation on 1/21/15 at 1:00 PM, DME noted in home included a stander lift, called a Get-U-Up lift.</p> <p>A. During home visit observation on 1/21/15 at 1:00 PM, patient # 10 indicated the agency has never sent anyone out (nurse) to competency test any of the home health aides (HHA) on the stander lift, the patient has had to orient the HHAs to the lift themselves, and the agency has it listed as a Hoyer lift on the plan of care.</p> <p>B. The Aide Care Plan dated 9/15/14 and reviewed on 11/11/14 and 1/8/15 stated "Hoyer lift" in the transfer/assist section.</p> <p>C. During interview on 1/21/15 at 2:38 PM, employee A indicated the agency did not know this patient had a different lift and not a Hoyer lift.</p>		<p>completed by 2/13/15 and documentation of the education will be maintained in the QI binder. Clinical record for patient #10 will be reviewed and Plan of Care updated to include proper Stander Lift. Additionally 100% of medical records will be reviewed, including clinical record for patient #10, to ensure that all Plans of Care include all DME used by the patient by 2/20/15.</p> <p>To ensure this alleged deficiency does not recur, during the quarterly self-audit, the DOCS or designee will review the Plans of Care on 10 or 10% of total patient records, whichever is greater, to ensure the Plan of Care includes all DME used by the patient. Additionally, during the quarterly self-audit, the DOCS or clinical designee will conduct a minimum of 5 patient observation visits and will compare the DME in the home with the DME listed on the Plans of Care to ensure the Plan of Care includes all DME used by the patient.</p> <p>The Accounts Manager/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur.</p> <p>Completion Date: 2/20/15</p>				

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N000546	<p>2. The agency's policy titled "Home Health Certification and Plan(s) of Care," # HH-CL-007.6, effective 11/10/14, states "5.3. The Plan of Care shall include, but not limited to: ... 5.3.4. Listing of equipment and supplies."</p> <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, policy review, and interview, the agency failed to inform the physician of a change in condition for 1 of 10 clinical records reviewed, creating the potential to affect all the agency's 73 patients. (# 8)</p> <p>Findings include</p> <p>1. Clinical record # 8, start of care date 5/4/09, contained a plan of care (POC) dated 11/6/14-1/4/15 with a diagnosis of Multiple Sclerosis and orders for home health aide (HHA) 34-56 hours a week times 60 days and skilled nursing (SN) 1</p>	N000546	<p>Response to N 0546 Internal Clinical Staff will be re-educated on CompanyPolicy titled "Physician Responsibility in Managing Care" to include therequirement to promptly inform the physician of a significant change in patientcondition as well as the requirement to document the physician notification inthe clinical record. This education willbe completed by 2/13/15 and documentation of the education to be maintained inthe QI binder. Beginning 2/16/15, the DOCS or designee will track allreports of changes in patient condition, including patient #8, to ensure</p>	02/20/2015

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	<p>visit three times weekly times 60 days. The POC contained general orders for SN as skilled observation and assessment every shift and as needed for signs of distress including: ... pain and symptom control, ... safety measures, ... mental status. ... signs and symptoms of abnormalities to any of the above are to be reported to the MD.</p> <p>A. The clinical document dated 11/30/14 by employee F, HHA, stated "Around 10 AM I was getting [patient] up had [patient] in Hoyer lift. I pulled the Hoyer lift out and than turned [patient] so feet wouldn't drop on the bed and [patient] fell. When I looked down the hooks were still connected to the blue pad underneath [patient]. So I hurried and unhooked them to check [patient] out. [Patient] wanted me to get [patient] up so I re-hooked the Hoyer lift got [patient] in chair like [patient] requested. I then called Maxim and I told [employee J] everything that happened. [employee J] told me a nurse would call me. When nurse did [nurse] asked what happened I told [nurse] and told [nurse] [patient] had a knot on [patient's] left side head and that [patient's] left shoulder hurt, [nurse] told me to call 911 and to call [nurse] back. So I called 911 and they came to access [patient] and check [patient] vitals, they did and said everything was</p>		<p>thatrequired follow up, including notification to physician, has occurred per Companypolicy. DOCS or designee will review thechange in condition tracker, as well as applicable patient record, weekly, tovalidate that the physician was promptly notified of any significant change inpatient condition.</p> <p>To ensure this alleged deficiency does not recur, during thequarterly self-audit, the DOCS or designee will review 10 or 10% of totalpatient records, whichever is greater, to ensure that the physician waspromptly notified of any significant changes in patient condition.</p> <p>The Accounts Manager/designee or Director of ClinicalServices/designee will be responsible for monitoring these corrective actionsto ensure that the alleged deficiency is corrected and will not recur.</p> <p>Completion Date: 2/20/15</p>	

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	<p>fine, asked [patient] if [patient] wanted to go in, [patient refused] and then told me to just keep an eye on [patient]. I called the nurse back, told [nurse] what was going on and [nurse] told me also to keep an eye on [patient] and write a clinical documentation."</p> <p>B. During interview on 1/14/15 at 12:05 PM, employee A indicated when a patient falls in the home, the policy is the HHA should call 911 and when the patient is safe then the HHA needs to call the office. If the patient refuses EMS we go do a change in condition visit. On 11/30/14 after the patient fell, the HHA notified the office first, and then 911 was called and the HHA reported the EMS said the patient was stable. Employee A indicated that on 12/1/14 the normal HHA went to care for the patient and called the office saying the patient reported they were not feeling right, so the HHA called 911 and the patient was taken to the emergency room, and found out the patient had a broken shoulder.</p> <p>C. The clinical record failed to evidence the physician was notified of the patient's fall until 12/9/14. Note: This fall resulted in the patient having a fractured shoulder.</p> <p>D. During interview on 1/15/15 at</p>						

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	<p>12:30 PM, employee A indicated they notified the physician on 12/9/14 of the incident from 11/30/14 as soon as they found out it had not yet been reported.</p> <p>2. During interview on 1/22/15 at 10:30 AM, employees A and B indicated the agency has weekly care coordination meetings to discuss staff issues etc and these are mandatory for everyone, otherwise the communication notes in the computer are to be used for care coordination.</p> <p>3. The agency's policy titled "Physician Responsibility in Managing Care," # MD-CL-005.3, effective 9/1/14, states "4.3. The office's role will include but is not limited to: ... 4.3.1. Timely communication to physician regarding his/her patient to include: 4.3.1.1. Changes in the patient condition. ... 4.3.3. To assist in continuity of care, including ongoing updates, written summaries, and phone consultation."</p>			

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N000550	<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 review, and policy review, the agency failed to ensure the registered nurse prepared the home health aide (HHA) assignment sheets according to physician orders for 1 of 5 records reviewed of patients receiving HHA services, creating the potential to affect all the agency's patients who receive HHA services. (# 6)</p> <p>Findings include</p> <p>1. Clinical record #6, SOC 3/13/12, contained a POC dated 8/29-10/27/14 21-35 hours a week for 60 days and skilled nurse monthly and as needed for Foley change for 60 days. HHA to monitor blood pressure daily and in a</p>	N000550	<p>Response to N 0550 Internal Clinical Staff will be educated on Company Policy titled "Home Health Aide Plan of Care" to include the requirement for the registered nurse (RN) to prepare the home health aide (HHA) assignment sheets according to physician orders. This education will be completed by 2/13/15 and documentation of the education to be maintained in the QI binder. 100% of HHA patient's clinical records, including clinical record for patient #6, will be reviewed to ensure that the HHA Care Plans include the Physician Orders as indicated on the 485 Plan of Care. This review will be completed by 2/13/15 and all HHA Care Plans, including HHA Care Plan for patient</p>	02/20/2015

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	<p>sitting position and record, bed bath daily in morning and per request, hair care in morning, assist with mouth care daily and per request, skin care daily after bath and request, dressing in morning, before bed and per request, shave per request, nail care weekly, denture care per request, incontinent care immediately upon soiling, peri-care after each bowel movement, peri care and clean around Foley catheter, transfer client from bed to chair using Hoyer lift each morning, assist with repositioning, transfer from chair to be each evincing via Hoyer lift, ROM active/passive each shift all extremities and light housekeeping each shift.</p> <p>2. The HHA care plan dated 8/26/14 stated "total bed bath, assist with shaving, transfer assist, assist in/out of bed, reposition, ROM active and passive, catheter care, empty catch bag, incontinence/peri care, last bowel movement, hair care/shampoo, mouth care, skin care, nail care, prepare meal, serve meal, encourage fluids, housekeeping." All tasks assigned were noted by asterisk in reference to "Check box under comments if patient/caregiver is functionally and cognitively able to make the choice." The box marked Vital Signs was checked NO and the special instructions section stated "1. Vital signs</p>		<p>#6, will be updated according to Physician Orders by 2/20/15. To ensure this alleged deficiency does not recur, during the quarterly self-audit, the DOCS or designee will review 10 or 10% of total patient records, whichever is greater and will include and equal mix of Skilled and Unskilled clinical records, to ensure the HHA Care Plans include the Physician Orders as indicated on the 485 Plan of Care for the unskilled clinical records. The Accounts Manager/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur. Completion Date: 2/20/15</p>	

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N000593	<p>upon client or supervisor request." The registered nurse failed to assign vitals per physician order.</p> <p>The Aide Weekly Notes dated 9/1, 9/2, 9/3, 9/4, 9/5, 9/8, 9/9, 9/10, 9/11/14 failed to evidence the HHA performed blood pressure daily.</p> <p>3. The agency's policy titled "Home Health Aide Plan of Care," # HH-CL-008.5, effective 4/7/14, states, "3.1. The Home Health Aide Plan of Care (HHA POC) will be individualized to the specific patient and will include at least: ... 3.1.1. Type of services/procedures to be provided, ... 3.1.7. Activities permitted, 3.1.8. Nutritional requirement, if relevant, 3.1.9. Specific procedure(s) to be performed, including amount, frequency and duration, 3.1.10. Safety measure, including specific equipment.</p> <p>410 IAC 17-14-1(k) Scope of Services Rule 14 Sec. 1(k) The training of home health aides pursuant to a continuing education program must be performed by or under the general supervision of a</p>			

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	<p>registered nurse.</p> <p>Based on employee file review, job description review, policy review, and interview, the agency failed to ensure home health aides (HHA) were trained by a registered nurse for 4 of 8 HHA employee files reviewed, creating the potential to affect all of the agency's 40 HHA only patients. (C, E, F, and L)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During interview on 1/15/15 at 8:48 AM, employee F indicated they did not have any person in the Hoyer lift when they were competency tested for the skill in the skills lab at Maxim, and they were trained at the patient's home by the other HHA. 2. During interview on 1/16/15 at 9:07 AM, employee F indicated they were not asked to be competency tested on the Hoyer again after patient # 8 fell. Employee F indicated they also care for patient # 10 who has a stand up lift, and the previous HHA working at that home trained employee F for everything, including the stand up lift which they had never used prior. 3. During home visit observation on 1/21/15 at 12:55 PM, employee S indicated the agency only asked if they 	N000593	<p>Response to N 0593</p> <p>HHA's currently assigned to patient #8, including employees E and F, have had competency reassessed by an RN on the Hoyer lift using a live person as of 1/22/15. Going forward, all staff assigned to patient #8 will have competency assessed by an RN on the Hoyer lift, as well as all other DME used and skills the aide is to perform on this patient, prior to being permitted to perform direct independent patient care. Competencies are documented on the HHA's competency assessment forms. As further detailed below, competency assessment forms have been updated to specifically indicate the type of DME used in the competency assessment, including the Hoyer lift, as well as to include an acknowledgement by the evaluator and the aide that the competency was performed on a live person.</p> <p>HHA's currently assigned to patient #10, including employee F, have had competency assessed by an RN on the stander lift on as of 1/22/15. Going forward, all staff assigned to patient #10 will have competency assessed by an RN on the stander lift, as well as other DME used and skills the aide is to perform on this patient, prior to being permitted to perform direct independent patient care. Competencies are</p>	01/27/2015			

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	<p>have ever used a stander lift before and told them to watch employee F.</p> <p>4. During home visit observation on 1/21/15 at 1:00 PM, patient # 10 indicated the agency has never sent anyone out (nurse) to competency test any of the HHAs on the stander lift, the patient has had to orient the HHAs to the lift themselves, and the agency has it listed as a Hoyer lift on the plan of care.</p> <p>5. During interview on 1/14/15 at 2:15 PM, employee I indicated they typically do not do skill competencies in the patients' homes unless there is something the agency does not have in the lab.</p> <p>6. The agency's job description titled "Director of Clinical Services (DOCS)," effective 3/5/13, states, "Essential Duties and Responsibilities: Responsible for maintaining compliance with applicable local, state, and federal regulations, Company policies and procedures, and accrediting agency requirements. ... Manages and providers to all clinical personnel ongoing education, in-service training programs, and competency evaluations to enhance quality patient care.</p> <p>7. The agency's policy titled "Competency Assessment-Direct Care</p>		<p>documented on the HHAs' competency assessment forms.</p> <p>100% review of Medical Records and personnel files will be completed to identify all patients with Hoyer lift and stander lift, as well as all HHAs assigned to patients with Hoyer lifts and stander lift. Each Aide assigned to a patient with a Hoyer lift and/or stander lift, including employees C, E, F and L, will have competency reassessed by an RN on the Hoyer lift and/or stander lift using a live person. Competencies will be documented on the HHAs competency assessment form. Competency assessment form will specifically indicate Hoyer competency and/or stander lift competency was completed with acknowledgement by the evaluator and the aide that the competency was performed on a live person by 1/22/15. Aides not re-comped by 1/22/15, or Aides assessed as not competent in using the Hoyer lift and/or stander lift, will be placed on Active Restricted status and will be removed from assigned schedule until competency completed and documented appropriately. Once competency re-assessed and aide assessed to be competent in using the Hoyer lift and/or stander lift, aide will be removed from Active Restricted status and placed on Active status and be permitted to provide direct</p>	

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NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4646 W JEFFERSON BLVD STE 100 FORT WAYNE, IN 46804			
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	<p>Staff," # MD-HR-008.6, effective 1/5/15, states, "3.1. The Company is responsible for the design and implementation of its competency assessment program. ... 3.2.2. For unskilled staff (HHA, CNA, etc.) the competency assessment must be performed on a person. The use of a mannequin for unskilled staff skills competency assessment is not acceptable. The evaluation may occur in the patient/client's residence, the office skills laboratory, a skilled nursing facility, hospital, or other healthcare facility. 3.3. Competency assessment is conducted initially during orientation and annually thereafter. ... 3.3.3. No Direct Care Staff may independently provide care to a patient without having previously been deemed as competent to provide the care for the assigned patient. ... 3.4. An established protocol will be used as a guideline for competency assessment. 3.4.1. The reference for the protocols is the most current version of the Visiting Nurses of America Nursing Procedure Manual. ... 3.5.1.1. For each competency assessment which requires the evaluation of the employee's management or use of a piece of equipment or supplies and the specific piece of equipment or supplies is not available in the office, the DOCS or clinical designee may arrange for the equipment validation component of the</p>		<p>independent patient care with patients who have Hoyer or Stander lifts.</p> <p>Aide assessed as not competent in using DME, including the Hoyer lift and/or stander lift, or any other skills the aide is to perform, will be placed on Active Restricted status and will be removed from assigned schedule until competency reassessed by the RN. Once competency re-assessed by the RN, and aide assessed to be competent in using DME, including the Hoyer lift and/or stander lift, or any other skills the aide is to perform, aide will be removed from Active Restricted status and placed on Active status and be permitted to provide direct independent patient care.</p> <p>Ongoing, all HHAs competency assessment forms will be modified to include a checklist of the specific equipment, including Hoyer lift, as well as an area to write in other specific equipment, i.e. stander lift, slide board, etc, used during competency assessment. RN evaluator and aide will acknowledge, on the competency assessment form, the use of a live person during competency assessments. DOCS or designee will review all initial and annual/ongoing aide competency assessment forms to ensure proper comps, including the</p>				

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	<p>competency assessment to be completed in an alternate location. ... 5.4.1.3. The following competencies must be evaluated while the aide is performing the task with a person: ... 5.4.1.3.9. Safe transfer techniques and ambulation. ... 5.5.1. Annual competency assessment must be completed at least annually (onetime per calendar year). Additional competencies may be required for change in patient assignment, performance issues, new technology or other indications at the discretion of the DOCS or clinical designee."</p> <p>8. The agency's policy titled "Patient/Client Scheduling," # MD-CL-016.4, effective 9/1/14, states, "3.3. Patient/client scheduling requires communication ... The scheduler may not assign an employee to a patient/client that has not been deemed as competent to provide care to a particular patient/client without approval from the DOCS or clinical designee. This approval is documented and maintained in the medical record."</p>		<p>Hoyer, stander lift and any other specific DME comp, have been completed bythe RN on a live person and that the specific equipment is properly documentedprior to aide providing direct independent patient care. DOCS or designee will initial bottom cornerof competency assessment form to indicate this review was completed. Aides will be placed on Active RestrictedStatus and will not be permitted to provide direct independent patient careuntil this review is completed and documented. Once the review is complete and documented, the aide will be removedfrom Active Restricted Status and placed on Active Status and be permitted toprovide direct independent patient care. No HHA may independently provide careto a patient without having previously been deemed competent, by an RN, toprovide the care for the assigned patient.</p> <p>All office staff will be educated on theappropriate competency assessment process, including the existing policyrequirement that all unskilled workers shall be assessed by an RN using a liveperson and that the specific equipment must be recorded when performing acompetency assessment, by the DOCS and AM/designee. This education will be documented andmaintained in the QI binder. Each staffmember will sign an</p>		

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N000596	410 IAC 17-14-1(I)(A) Scope of Services Rule 14 Sec. 1(I) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section		<p>acknowledgement form to indicate receipt and understanding of new process.</p> <p>To ensure this alleged deficiency does not recur, during quarterly self-audits, the DOCS or designee will review 10 or 10% of total patient records, whichever is greater as well as 10 or 10% of total personnel files whichever is greater. This review will include an equal mix of Skilled and Unskilled clinical records as well as a mix of skilled and unskilled worker files, to ensure HHA competency Assessments, including Hoyer, stander lift and other specific DME comps, as well as all other skills the aide will perform, were completed by an RN on a live person, and that the specific equipment used in the assessment is properly documented.</p> <p>The Administrator/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur. Completion date: 1/27/15</p>	

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	<p>as follows:</p> <p>(1) The home health aide shall:</p> <p>(A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and</p> <p>Based on home visit observation, policy review, and interview, the agency failed to ensure all home health aides (HHA) received adequate skills competency testing prior to being placed in patient homes to provide care for for 2 of 10 clinical records reviewed, creating the potential to affect all the agency's patents. (# 8 and 10)</p> <p>Findings include</p> <p>1. Clinical record # 8 start of care (SOC) date 5/4/09 contained a plan of care (POC) dated 11/6/14-1/4/15 with a diagnosis of Multiple Sclerosis and orders for home health aide (HHA) 34-56 hours a week times 60 days, and skilled nursing (SN) 1 visit three times weekly times 60 days. The POC contained general orders for SN as skilled observation and assessment every shift and as needed for signs of distress including: ... pain and symptom control, ... safety measures, ... mental status. ... signs and symptoms of abnormalities to any of the above are to be reported to the MD.</p>	N000596	<p>Response to N 0596</p> <p>HHAs currently assigned to patient #8, including employees E and F, have had competency reassessed on the Hoyer lift using a live person as of 1/22/15. Going forward, all staff assigned to patient #8 will have competency assessed on the Hoyer lift, as well as all skills the aide is to perform on this patient, prior to being permitted to perform direct independent patient care. Competencies are documented on the HHAs' competency assessment forms. As further detailed below, competency assessment forms have been updated to specifically indicate Hoyer competency was completed with acknowledgement by the evaluator and the aide that the competency was performed on a live person.</p> <p>HHAs currently assigned to patient #10, including employee F, have had competency assessed on the stander lift on as of 1/23/15. Going forward, all staff assigned to patient #10 will have competency assessed on the stander lift, as well as all skills the aide is to perform on this patient, prior to being permitted to perform direct independent patient care.</p>	01/27/2015
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	<p>A. The clinical documentation dated 11/30/14 by employee F, HHA, stated "Around 10 AM I was getting [patient] up had [patient] in Hoyer lift. I pulled the Hoyer lift out and than turned [patient] so feet wouldn't drop fro the bed and [patient] fell. When I looked down the hooks were still connected to the blue pad underneath [patient]. So I hurried and unhooked them to check [patient] out. [Patient] wanted me to get [patient] up so I re-hooked the Hoyer lift got [patient] in chair like [patient] requested. I then called Maxim and I told [employee J] everything that happened. [employee J] told me a nurse would call me. When nurse did [nurse] asked what happened I told [nurse] and told [nurse] [patient] had a knot on [patient's] left side head and that [patient's] left shoulder hurt, [nurse] told me to call 911 and to call [nurse] back. So I called 911 and they came to access [patient] and check [patient] vitals, they did and said everything was fine, asked [patient] if [patient] wanted to go in, [patient refused] and then told me to just keep an eye on [patient]. I called the nurse back , told [nurse] what was going on and [nurse] told me also to keep an eye on [patient] and write a clinical documentation."</p> <p>B. During interview on 1/14/15 at 12:05 PM, employee A indicated when a</p>		100% review of Medical Records and personnel files will be completed to identify all patients with Hoyer lift and stander lift as well as all HHAs assigned to patients with Hoyer lifts and stander lift. Each Aide assigned to a patient with a Hoyer lift and/or stander lift, including employees C, E, F and L, will have competency reassessed on the Hoyer lift and/or stander lift using a live person. Competencies will be documented on the HHAs competency assessment form. Competency assessment form will specifically indicate Hoyer competency and/or stander lift competency was completed with acknowledgement by the evaluator and the aide that the competency was performed on a live person by 1/22/15. Aides not re-comped by 1/22/15, or Aides assessed as not competent in using the Hoyer lift and/or stander lift, will be placed on Active Restricted status and will be removed from assigned schedule until competency completed and documented appropriately. Once competency re-assessed and aide assessed to be competent in using the Hoyer lift and/or stander lift, aide will be removed from Active Restricted status and placed on Active status and be permitted to provide direct independent patient care with patients who have Hoyer or Stander lifts.				

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	<p>patient falls in the home, the policy is the HHA should call 911 and when the patient is safe then the HHA needs to call the office. If the patient refuses EMS we go do a change in condition visit. On 11/30/14 after the patient fell, the HHA notified the office first, and then 911 was called and the HHA reported the EMS said the patient was stable. Employee A indicated that on 12/1/14 the normal HHA went to care for the patient and called the office saying the patient reported they were not feeling right, so the HHA called 911 and the patient was taken to the emergency room, and found out the patient had a broken shoulder.</p> <p>C. During home visit observation on 1/20/15 at 12:50 PM, patient #8 indicated their family member told agency employee H, several times, that employee C needed to be re-trained on the Hoyer lift but that never happened.</p> <p>D. During interview on 1/15/15 at 9:52 AM, employee E indicated some of the HHAs sent to patient #8's home do not know how to use a Hoyer lift, don't know how to use the Hoyer pad or position it, and don't know how to hook it tup. Employee E indicated one HHA actually tried to put the hole in the pad over the patient's head.</p>		<p>Aide assessed as not competent in using the Hoyer lift and/or stander lift, or any other skill the aide is to perform, will be placed on Active Restricted status and will be removed from assigned schedule until competency reassessed. Once competency re-assessed and aide assessed to be competent, aide will be removed from Active Restricted status and placed on Active status and be permitted to provide direct independent patient care.</p> <p>Ongoing, all HHAs competency assessment forms will be modified to include a checklist of the specific equipment, including Hoyer lift, as well as an area to write in other specific equipment, i.e. stander lift, used during competency assessment. Evaluator and aide will acknowledge, on the competency assessment form, the use of a live person during competency assessments that occur in the office skills lab. DOCS or designee will review all initial and annual/ongoing aide competency assessment forms to ensure proper comps, including the Hoyer and stander lift comp, have been completed on a live person and that the specific equipment is properly documented prior to aide providing direct independent patient care. DOCS or designee will initial bottom corner of competency</p>	

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	<p>2. Clinical record # 10, SOC date 9/15/14, contained a POC dated 11/14/14-1/12/15 with orders for HHA 25-42 hours per week for 60 days. DME listed included Hoyer lift. During home visit observation on 1/21/15 at 1:00 PM, DME noted in home included a stander lift, called a Get-U-Up lift.</p> <p>A. During home visit observation on 1/21/15 at 1:00 PM, patient # 10 indicated the agency has never sent anyone out (nurse) to competency test any of the HHAs on the stander lift, the patient has had to orient the HHAs to the lift themselves, and the agency has it listed as a Hoyer lift on the plan of care.</p> <p>B. During interview on 1/16/15 at 9:07 AM, employee F indicated they were not asked to be competenced on the Hoyer again after patient # 8 fell. Employee F indicated they also care for patient # 10 who has a stand up lift, and the previous HHA working at that home trained employee F for everything, including the stand up lift which they had never used prior.</p> <p>3. The agency's policy titled "Competency Assessment-Direct Care Staff," # MD-HR-008.6, effective 1/5/15, states "3.2. ... An employee self-skills assessment tool alone is not sufficient to</p>		<p>assessment form to indicate this review was completed. Aides will be placed on Active RestrictedStatus and will not be permitted to provide direct independent patient careuntil this review is completed and documented. Once the review is complete and documented, the aide will be removedfrom Active Restricted Status and placed on Active Status and be permitted toprovide direct independent patient care.</p> <p>All office staff will be educated on theappropriate competency assessment process, including the existing policyrequirement that all unskilled workers shall be assessed using a live personand that the specific equipment must be recorded when performing a competencyassessment, by the DOCS and AM/designee. This education will be documented and maintained in the QI binder. Each staff member will sign anacknowledgement form to indicate receipt and understanding of new process.</p> <p>In addition to the Standard cited, thestatement of deficiency included allegations that are more fully discussed the correctionsfor items G107/N514 (Exercise of Rights and Respect for Property) and G173/N542(Duties of the Registered Nurse).</p>	

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	<p>evaluate competency. ... 3.2.2. For unskilled staff (HHA, CNA, etc.) the competency assessment must be performed on a person. ... 3.3. Competency assessment is conducted initially during orientation and annually thereafter. 3.3.1. Competency assessment is specific to the role and job responsibilities of the individual Direct care Staff. ... 3.3.3. No Direct Care Staff may independently provide care to a patient without having previously been deemed as competent to provide the care for the assigned patient. ... 3.4.1. The reference for the protocols is the most current version of the Visiting Nurses of America Nursing Procedure Manual. ... 3.7. a Patient specific Orientation (PSO) is required to be completed prior to the start of an assignment for each direct care staff assigned to a patient receiving shift and/or hourly care and/or services. ... 4. Definitions: ... 4.8. Skills validation: The evaluation of direct care staff's knowledge and ability to operate a piece of equipment, supplies or procedures. A skills validation also includes the evaluation of the care and management of a patient receiving the care or procedure, ... each clinician must complete a full demonstration of the equipment and/or procedure to be considered as qualified to provide service to an assigned patient who requires such skills."</p>		<p>To ensure this alleged deficiency does not recur, during quarterly self-audits, the DOCS or designee will review 10 or 10% of total patient records, whichever is greater as well as 10 or 10% of total personnel files whichever is greater. This review will include an equal mix of Skilled and Unskilled clinical records as well as a mix of skilled and unskilled worker files, to ensure HHA competency Assessments, including Hoyer and stander lift comps, as well as all skills the aide is to perform, were completed and that the specific equipment used in the assessment is properly documented as well as to ensure that assigned aides were competency assessed on the relevant transfer equipment.</p> <p>The Accounts Manager/designee or Director of Clinical Services/designee will be responsible for monitoring these corrective actions to ensure that the alleged deficiency is corrected and will not recur. Completion date: 1/27/15</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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