STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157591	A. BUILDING 00 B. WING	04/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAXIM HEALTHCARE SERVICES INC	4646 W JEFFERSON BLVD STE 100 FORT WAYNE, IN 46804

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G 0000 Bldg. 00	This was a federal home health complaint investigation. Complaint #: IN00193591- Substantiated: Federal deficiencies related to the allegation are cited. IN00163848- Unsubstantiated. Unrelated deficiencies are cited. IN00195924- Unsubstantiated. Unrelated deficiencies are cited. Survey Date: March 18 & 21, April 5 & 11, 12, 13, 14, 15, 18 and 19, 2016 Facility #: IN003757 Medicaid #: 200484160 Maxim Healthcare Services INC was found to be out of compliance with the Conditions of Participation 42 CFR 484.10 Patient Rights; 484.18 Acceptance of patients, plan of care & medical supervision; and 484.48 Clinical records, as related to these complaints.	G 0000	By submitting this POC the agency does not admit theallegations in the survey report or that it violated any regulations. The agency is submitting this POC in responseto its regulatory obligations and commitment to compliance. The agency further reserves the right tocontrast any alleged findings, conclusions and deficiencies. The agency intends to request that this POCservice as its Credible Allegation of Compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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G 0100 Bldg. 00	Based on document review and interview, the agency failed to ensure staff treated patient property with respect (See G 105); and failed to document the existence of 2 patient complaints in the grievance log, failed to ensure all allegations were investigated for 1 complaint, and failed to follow its own policy for 2 complaints (See G 107). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.10 Patient Rights.	G 0100	See Response for: G105 and G107	05/27/2016
G 0105 Bldg. 00	484.10(b)(3) EXERCISE OF RIGHTS AND RESPECT FOR PROP The patient has the right to have his or her property treated with respect. Based on document review and	G 0105	Employee K was given verbal	05/19/2016

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	interview, the agency failed to ensure staff treated patient property with respect for 1 of 1 agency. Findings include 1. The record for patient # 2 was reviewed on 4/5/16. The start of care date was 12/18/15. The record contained a plan of care dated 12/17/15-2/14/16 with orders for HHA 3-5 days per week, 7 to 10 hours per week, for 60 days, plus 18 hours a month Attendant care, and 15 hours per month of Homemaker via waiver. A. The Client/Facility Logging Report dated 2/4/16 at 2:00 PM, evidenced employee E (Registered Nurse Clinical Supervisor) had conducted a visit for patient #2 and noted the client had multiple accusations against the HHA, employee K. Employee E noted the patient complained that the HHA was constantly asking the patient for the Vicodin pills and some came up missing; the patient reported the prescription needed to be refilled and the HHA is constantly asking the patient to refill them; patient claimed they did not give any to the HHA but is reluctant to fill the prescription due to the HHA asking; patient reported the HHA was asking the patient to sign time sheets she did not		correction and re-education on 5/13/2016. Employee N was given verbal correction and re-education on5/11/2016. All internal office staff will be re-educated on CompanyPolicy titled “Patient/Client Rights and Responsibilities” #MD-ERR-001.6 toensure that all internal staff members understand the requirement to ensure Employeestreat Patient’s property with respect. TheClinical Manager/Accounts Manager/Designee will provide this education withattendance acknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. A grievance for Patient #2 specifically related to employeeN was opened on 4/12/16 and closed on 4/19/16 after an internal investigationwas completed. An office process will be developed, based on the currentGrievance Policy, in order to ensure that all complaints or concerns regarding treatmentor care that is (or fails to be) furnished, or regarding the lack of respect of patient’s property byanyone furnishing services are documented and investigated with resolution. This process will include a weekly review ofthe grievance log by the Clinical Manager and AM/designee to ensure that allcomplaints and concerns have been documented and are being investigated perCompany policy. All internal	

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	work and was leaving early; patient claimed HHA left shifts early to buy cigarettes for the HHA's significant other, and while out for doctor appointment the HHA stopped by her house to pick up her significant other; patient claimed the HHA used the patient's credit card to buy herself a sandwich; HHA was not taking the patient's blood pressures as ordered by the physician; HHA was not completing housekeeping duties properly; and HHA was not properly bathing the patient and/or not being in the bathroom while the patient was in the shower. 1. The agency complaint/grievance log failed to evidence these accusations had been documented as of 3/18/16. 2. During interview on 4/5/16 at 1:55 PM, employee D (Alternate Administrator) stated all active legal issues do not go in the complaint/grievance log due to the nature of the allegations. Employee F (Administrative Officer) stated this was a legal issue versus a grievance so once the investigation is complete then it will be filed in the grievance log. 3. The document titled "Incident Report: Interview Summary" was provided on 4/5/16. This document was dated 2/5/16 and was the interview of		officestaff will be educated on the new process, including existing Company Policytitled “Grievance and Complaints” #MD-ERR-005.7. The Clinical Manager/AccountsManager/Designee will provide this education with attendance acknowledgment andrespective documents to be kept in the QI Binder. To be completed by 5/19/2016. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, as wellas the Grievance log, will be audited quarterly to ensure that all complaints,including those related to lack of respect of property, are documented andinvestigated per policy. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur.	

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	HHA employee K, by the Administrator and Alternate Administrator. This document stated "[employee K] stated she had never taken or asked for medication. She stated all medications are kept on top of the fridge in a lock box and [patient] keeps the key close ... at all times. ... [Employee K] stated she would not forge any times and the only time she left early was on 2/4/2016 when [employee K's spouse] broke [employee's] hand. [Patient] signed that time sheet. ... [When asked about leaving to take spouse cigarettes, employee K] stated that was not true. ... [When asked about using patient credit card to buy herself a sandwich, employee K] admitted to this but stated [patient] had given her permission to do so because [employee K] had bout [patient] food once before. The AM and DOCS addressed this during the interview. We reeducated [employee K] that she is not to buy food for patients with her money and she is not to accept food from patients. [Patient stated aide not taking blood pressures on a consistent basis, employee K] admitted to this, but reeducation was done in the home when this was reported. [Patient stated employee K did a poor job cleaning the client's home, employee K] stated she does clean the home on a daily basis. We the AM and DOCS did their in-home			

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	case conference and the home was very clean. [Patient stated employee K would not help patient shower and bathe, employee K] stated [patient] would go to the bathroom by [self] and not allow [employee K] to provide care during those times. The AM reached out to the other families [employee K] works for and they had nothing but positive things to say about [employee K], not a single other patient had any issues." This interview failed to include investigation of the allegation that the employee stopped by their house to pick up their significant other while out for a physician appointment with the patient. 4. The document titled "Incident Report: Interview Summary" was provided on 4/5/16. This document was dated 2/8/16 and was the interview of patient # 2, by the Administrator, Alternate Administrator, and employee P (Recruiter/Scheduler). This document stated "We asked [patient #2] to clarify ... allegation of [employee K] asking and taking medications- [patient] stated [employee K] never took anything, but would ask [patient] to schedule an appointment with ... pain specialist because [patient] would let [employee] know [patient/s] pain medication is almost gone. [Patient] stated [employee K] would ask ... on a daily basis if the			

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	appointment had been made and [patient] was tired of [employee] asking so [patient] decided [patient] wasn't going to go to the pain specialist. We asked [patient] if [employee K] had access to ... locked medication box, [patient] said no. We asked [patient] to clarify [employee K] leaving early and forging time sheets- [patient] stated [they] really didn't remember [employee K] leaving early and doesn't pay attention to the times when [patient] signs off on time sheets. We asked [patient] to clarify [employee K] leaving to buy [employee's spouse] cigarettes- [patient] stated that [employee K] would buy cigarettes for [employee's spouse] when they would go to Wal-Mart together but not take them to [employee's spouse] at work. We asked [patient] to clarify [employee K] using [patient's] credit card for a sandwich- [patient] stated that [patient] gave [employee K] ... card and told [employee K] it was ok for [employee K] to buy ... a sandwich since [employee K] had bought [patient] food previously. We made sure to clarify to [patient] ... is not to accept food from our aides and shouldn't let our aides buy their own food with [patient] money. We informed [patient, employee K] had been reeducated by our Clin Sup [employee E] on how to properly take blood pressure. We asked [patient] to clarify ... statement			

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	that [employee K] wasn't cleaning properly- [patient] stated that [employee K] does a good job. We asked [patient] if ... allows [employee K] to assist ... in the bathroom and shower. [Patient] stated [patient] does, but sometimes [employee K] does not want to help. (This is contradictory to [employee K's] interview). [Patient] stated ... would not like [employee K] back out to [their] home. We let [patient] know we did not have anyone in the pipeline for this area, but we would recruit. [Patient] stated [they] got in touch with an old aide and [that aide] said [they] had applied with Maxim. We informed [patient] that aide called us and told us [patient] got her fired from her last job and would never work in that home again no matter what company [patient] was with. We called [patient ' s] case manager to inform her of our case conference and she stated this isn't the first time [patient] had made the allegations against [patient ' s] aides and [patient] is a "home care company jumper"." This interview failed to include investigation of the allegation that the employee stopped by their house to pick up their significant other while out for a physician appointment with the patient. 5. The agency provided a document titled "Specimen Result			

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	Certificate" dated 3/3/16 for employee K drug screen. It stated "Specimen Type: Urine. ... Final Result Disposition: Negative." 6. During interview on 4/18/16 at 10:00 AM, the Administrator stated this complaint should have been documented in the complaint log as it is still a grievance, but was sent to the legal department due to the allegations of drugs missing it was recorded as an incident. The Administrator stated they have not had any further complaints about employee K. 7. During interview on 4/18/16 at 10:20 AM, the Administrator stated this investigation is not complete yet because apparently the patient also complained about another HHA (employee N) not completing tasks. 2. The agency's policy titled "Grievances and Complaints," # MD-ERR-005.7, date 1/11/16 stated, "4. Definitions: 4.1. Grievance: Any report (written or verbal) of dissatisfaction or concern with the care and or service delivery that does not result in actual or potential harm or danger to the patient/client and/or family/caregiver. A grievance is considered synonymous with complaint. ... 5.3. Grievances received from a			

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	patient/client and/or family/caregiver will be documented on a Patient Grievance form. ... 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 resolution and ensure satisfaction. ... 5.3.2.4. The investigation shall be completed within 30 days or sooner if required by law. ... 5.4. The DOCS, clinical designee or AM shall enter the grievance in the system of record. A recording of all investigative activities, outcomes and analyses shall be included in the report. 5.4.1. The documentation shall be maintained in the Grievance Binder." 3. The agency's policy titled "Patient/Client Rights and Responsibilities," # MD-ERR-001.6, dated 10/5/15 stated, "5.2. Home care patients/clients have the right to: 5.2.3. Be admitted for services only if the agency has the ability to provide safe, professional care ... and to provide continuity of care. ... 5.2.13. Have one's property and person treated with respect, consideration, and recognition of patient/client dignity and individuality. ... 5.2.15. Be free from mistreatment, and			

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	misappropriation of patient/client property. ... 5.2.16. Voice grievances/complaints regarding treatment or care that is or fails to be furnished, lack of respect of property."			
G 0107 Bldg. 00	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP 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. Based on document review and interview, the agency failed to document the existence of 2 patient complaints in the grievance log, failed to ensure all allegations were investigated for 1 complaint, and failed to follow its own policy for 2 complaints. (#2 and 5) Findings include 1. The agency complaint log was reviewed on 3/18/16. The complaint log failed to evidence any complaints about patients with ventilators, trachs, medical emergencies, or lack of care to such patients; and failed to evidence any	G 0107	Patient #2 was discharged on 4/14/2016. Patient #5 was discharged on 3/21/16. Employee K was given verbal correction and re-education on5/13/2016. Employee N was given verbal correction and re-education on5/11/2016. All internal office staff will be re-educated on CompanyPolicy titled "Patient/Client Rights and Responsibilities" #MD-ERR-001.6 toensure that all internal staff members understand the requirement to ensureEmployee's treat Patient's property with respect. The Clinical Manager/Accounts	05/19/2016

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	complaints of missing medications, and any complaints concerning patient #2 and employee K (HHA). 2. The record for patient # 2 was reviewed on 4/5/16. The start of care date was 12/18/15. The record contained a plan of care dated 12/17/15-2/14/16 with orders for HHA 3-5 days per week, 7 to 10 hours per week, for 60 days, plus 18 hours a month Attendant care, and 15 hours per month of Homemaker via waiver. A. The Client/Facility Logging Report dated 2/4/16 at 2:00 PM, evidenced employee E (Registered Nurse Clinical Supervisor) had conducted a visit for patient #2 and noted the client had multiple accusations against the HHA, employee K. Employee E noted the patient complained that the HHA was constantly asking the patient for the Vicodin pills and some came up missing; the patient reported the prescription needed to be refilled and the HHA is constantly asking the patient to refill them; patient claimed they did not give any to the HHA but is reluctant to fill the prescription due to the HHA asking; patient reported the HHA was asking the patient to sign time sheets she did not work and was leaving early; patient claimed HHA left shifts early to buy		Manager/Designeewill provide this education with attendance acknowledgment and respectivedocuments to be kept in the QI Binder. Tobe completed by 5/19/2016. An office process will be developed, based on the current GrievancePolicy, in order to ensure that all complaints or concerns regarding treatmentor care that is (or fails to be) furnished, or regarding the lack of respect of patient's property byanyone furnishing services are documented and investigated with resolution. This process will include a weekly review ofthe grievance log by the Clinical Manager and AM/designee to ensure that allcomplaints and concerns have been documented and are being investigated perCompany policy. All internal office staff will be educated onthe new process, including existing Company Policy titled "Grievance andComplaints" #MD-ERR-005.7. The Clinical Manager/Accounts Manager/Designee willprovide this education with attendance acknowledgment and respective documentsto be kept in the QI Binder. To becompleted by 5/19/2016. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, as wellas the Grievance log, will be audited quarterly to ensure that all complaintsmade by a	

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	cigarettes for the HHA's significant other, and while out for doctor appointment the HHA stopped by her house to pick up her significant other; patient claimed the HHA used the patient's credit card to buy herself a sandwich; HHA was not taking the patient's blood pressures as ordered by the physician; HHA was not completing housekeeping duties properly; and HHA was not properly bathing the patient and/or not being in the bathroom while the patient was in the shower. 1. The agency complaint/grievance log failed to evidence these accusations had been documented as of 3/18/16. 2. During interview on 4/5/16 at 1:55 PM, employee D (Alternate Administrator) stated all active legal issues do not go in the complaint/grievance log due to the nature of the allegations. Employee F (Administrative Officer) stated this was a legal issue versus a grievance so once the investigation is complete then it will be filed in the grievance log. 3. The document titled "Incident Report: Interview Summary" was provided on 4/5/16. This document was dated 2/5/16 and was the interview of HHA employee K, by the Administrator and Alternate Administrator. This		patient or the patient's family or guardian regarding treatment orcare that is (or fails to be) furnished, or regarding the lack of respect forthe patient's property by anyone furnishing services on behalf of the agency, aredocumented and investigated to resolution per policy. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur.	

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	document stated "[employee K] stated she had never taken or asked for medication. She stated all medications are kept on top of the fridge in a lock box and [patient] keeps the key close ... at all times. ... [Employee K] stated she would not forge any times and the only time she left early was on 2/4/2016 when [employee K's spouse] broke [employee's] hand. [Patient] signed that time sheet. ... [When asked about leaving to take spouse cigarettes, employee K] stated that was not true. ... [When asked about using patient credit card to buy herself a sandwich, employee K] admitted to this but stated [patient] had given her permission to do so because [employee K] had bout [patient] food once before. The AM and DOCS addressed this during the interview. We reeducated [employee K] that she is not to buy food for patients with her money and she is not to accept food from patients. [Patient stated aide not taking blood pressures on a consistent basis, employee K] admitted to this, but reeducation was done in the home when this was reported. [Patient stated employee K did a poor job cleaning the client's home, employee K] stated she does clean the home on a daily basis. We the AM and DOCS did their in-home case conference and the home was very clean. [Patient stated employee K would			

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	not help patient shower and bathe, employee K] stated [patient] would go to the bathroom by [self] and not allow [employee K] to provide care during those times. The AM reached out to the other families [employee K] works for and they had nothing but positive things to say about [employee K], not a single other patient had any issues." This interview failed to include investigation of the allegation that the employee stopped by their house to pick up their significant other while out for a physician appointment with the patient. 4. The document titled "Incident Report: Interview Summary" was provided on 4/5/16. This document was dated 2/8/16 and was the interview of patient # 2, by the Administrator, Alternate Administrator, and employee P (Recruiter/Scheduler). This document stated "We asked [patient #2] to clarify ... allegation of [employee K] asking and taking medications- [patient] stated [employee K] never took anything, but would ask [patient] to schedule an appointment with ... pain specialist because [patient] would let [employee] know [patient/s] pain medication is almost gone. [Patient] stated [employee K] would ask ... on a daily basis if the appointment had been made and [patient] was tired of [employee] asking so			

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	[patient] decided [patient] wasn't going to go to the pain specialist. We asked [patient] if [employee K] had access to ... locked medication box, [patient] said no. We asked [patient] to clarify [employee K] leaving early and forging time sheets- [patient] stated [they] really didn't remember [employee K] leaving early and doesn't pay attention to the times when [patient] signs off on time sheets. We asked [patient] to clarify [employee K] leaving to buy [employee's spouse] cigarettes- [patient] stated that [employee K] would buy cigarettes for [employee's spouse] when they would go to Wal-Mart together but not take them to [employee's spouse] at work. We asked [patient] to clarify [employee K] using [patient's] credit card for a sandwich- [patient] stated that [patient] gave [employee K] ... card and told [employee K] it was ok for [employee K] to buy ... a sandwich since [employee K] had bought [patient] food previously. We made sure to clarify to [patient] ... is not to accept food from our aides and shouldn't let our aides buy their own food with [patient] money. We informed [patient, employee K] had been reeducated by our Clin Sup [employee E] on how to properly take blood pressure. We asked [patient] to clarify ... statement that [employee K] wasn't cleaning properly- [patient] stated that [employee			

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	K] does a good job. We asked [patient] if ... allows [employee K] to assist ... in the bathroom and shower. [Patient] stated [patient] does, but sometimes [employee K] does not want to help. (This is contradictory to [employee K's] interview). [Patient] stated ... would not like [employee K] back out to [their] home. We let [patient] know we did not have anyone in the pipeline for this area, but we would recruit. [Patient] stated [they] got in touch with an old aide and [that aide] said [they] had applied with Maxim. We informed [patient] that aide called us and told us [patient] got her fired from her last job and would never work in that home again no matter what company [patient] was with. We called [patient ' s] case manager to inform her of our case conference and she stated this isn't the first time [patient] had made the allegations against [patient ' s] aides and [patient] is a "home care company jumper"." This interview failed to include investigation of the allegation that the employee stopped by their house to pick up their significant other while out for a physician appointment with the patient. 5. The agency provided a document titled "Specimen Result Certificate" dated 3/3/16 for employee K drug screen. It stated "Specimen Type:			

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	Urine. ... Final Result Disposition: Negative." 6. During interview on 4/18/16 at 10:00 AM, the Administrator stated this complaint should have been documented in the complaint log as it is still a grievance, but was sent to the legal department due to the allegations of drugs missing it was recorded as an incident. The Administrator stated they have not had any further complaints about employee K. 7. During interview on 4/18/16 at 10:20 AM, the Administrator stated this investigation is not complete yet because apparently the patient also complained about another HHA (employee N) not completing tasks. 3. The clinical record for patient # 5 was reviewed on 3/18/16. Start of care date was 3/10/16. The record contained a plan of care dated 3/10-5/8/16 with diagnosis of Chronic Respiratory failure with hypoxia, Dependence on respirator (ventilator), and Encounter for attention to tracheostomy and gastrostomy. The plan of care contained orders for Skilled Nursing (SN) services 12-20 hours per day, 5-7 days per week for 60 days. General orders for skilled observation and assessment every shift and as needed			

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	for signs of distress including vital signs (temperature, pulse, respirations, and oxygen levels) ... Respiratory orders including Astral 150 Ventilator to be worn 24 hours/day 7 days a week. A. The Nursing Flow Sheet dated 3/16/16 from 6:45 AM-2:05 PM charting stated "1:15 PM." Nothing was charted at 1:15 PM. The record failed to evidence the patient change in condition and actions taken by the nurse. B. During interview on 3/18/16 at 3:50 PM, the Administrator stated that the legal department told employee B (Licensed Practical Nurse) not to chart the incident until the investigation was complete but the agency did call him in for interview to begin the investigation that same day. C. During interview on 3/18/16 at 2:30 PM, the Administrator stated the incident that happened with patient #5 is a protected case, meaning she cannot give more than the chart until she contacts Maxim's legal department, but she could provide the incident report but no copies of it. The Administrator stated the incident happened on 3/16/16. 4. The agency's policy titled "Grievances and Complaints," # MD-ERR-005.7, date			

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	1/11/16 stated, "4. Definitions: 4.1. Grievance: Any report (written or verbal) of dissatisfaction or concern with the care and or service delivery that does not result in actual or potential harm or danger to the patient/client and/or family/caregiver. A grievance is considered synonymous with complaint. ... 5.3. Grievances received from a patient/client and/or family/caregiver will be documented on a Patient Grievance form. ... 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 resolution and ensure satisfaction. ... 5.3.2.4. The investigation shall be completed within 30 days or sooner if required by law. ... 5.4. The DOCS, clinical designee or AM shall enter the grievance in the system of record. A recording of all investigative activities, outcomes and analyses shall be included in the report. 5.4.1. The documentation shall be maintained in the Grievance Binder." 5. The agency's policy titled "Patient/Client Rights and Responsibilities," # MD-ERR-001.6, dated 10/5/15 stated, "5.2. Home care			

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	patients/clients have the right to: 5.2.3. Be admitted for services only if the agency has the ability to provide safe, professional care ... and to provide continuity of care. ... 5.2.13. Have one's property and person treated with respect, consideration, and recognition of patient/client dignity and individuality. ... 5.2.15. Be free from mistreatment, and misappropriation of patient/client property. ... 5.2.16. Voice grievances/complaints regarding treatment or care that is or fails to be furnished, lack of respect of property."			
G 0121 Bldg. 00	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, document review, and interview, the agency failed to ensure staff followed infection control policies and procedures for 1 of 5 home visit observations (patient # 1), failed to adequately meet the needs of 1 patient for 54 days due to lack of available staffing and failed to discharge the patient per policy. (#2) Findings include	G 0121	All directcare staff, including Employee G, were sent an in-service mailer on 5/6/16regarding proper handwashing procedure to include hand hygiene. Additionally all direct care staff, includingEmployee G, were provided with a Hand Washing flyer which includes guidelinesfor proper hand washing and hand hygiene on 5/6/16. Employee G was re-assessed on proper handwashing competency on	05/27/2016

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	1. During home visit observation for patient # 1 on 4/13/16 at 11:30 AM, employee G (HHA) was observed assisting patient with shower. Employee G failed to wash her hands longer than 10 seconds prior to donning gloves. After assisting with washing the patient's back, employee G doffed gloves, and failed to wash hands longer than 8 seconds. Employee G then proceeded to don new gloves and prepare tape for leg bag, when she doffed the gloves, she failed to wash hands for longer than 5 seconds. Prior to donning new gloves, employee G failed to wash hands for longer than 4 seconds, and after doffing the gloves she failed to wash hands for longer than 5 seconds. 2. During interview on 4/13/16 at 1:15 PM, employee J (Alternate Nurse Supervisor) stated employees are to wash hands for approximately 30 seconds, but may use hand sanitizer if the hands are not soiled, such as in between glove changes. 3. During interview on 4/18/16 at 11:00 AM, the Administrator stated the agency just did skills fair recently and all employees did perform hand washing. 4. The record for patient # 2 was reviewed on 4/5/16. The start of care		5/11/16. OngoingClinical Supervisors will observe proper handwashing by direct caregiversduring patient Supervisory Visits when staff are present and document thisobservation on the Supervisory Visit note. Ongoing direct caregivers, including Employee G, will have competency assessedon Infection Control, to include handwashing, annually during office annualskills fair. Patient #2 was discharged on 4/14/16. An office process will be developed, based on the currentMissed Shift Policy, in order to ensure that all missed shifts are documentedand supportive loggings will be entered. All internal office staff will be educated on the new process, includingexisting Missed Shifts Policy. The DOCS/AM/Designee will provide this educationwith attendance acknowledgment and respective documents to be kept in the QIBinder. To be completed by5/17/2016. In order to minimize the future recurrence of missed shifts,the Administrator/Clinical Manager and Accounts Manager/designee will implementand monitor a Recruitment Plan. All internal staff will be educated on thisplan by Accounts Manager/designee with attendance acknowledgement andrespective documents to be kept in the QI binder. **Recruitment Plan:** Our recruitment	

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	date was 12/18/15. The record contained a plan of care dated 12/17/15-2/14/16 with orders for HHA 3-5 days per week, 7 to 10 hours per week, for 60 days, plus 18 hours a month Attendant care, and 15 hours per month of Homemaker via waiver. The record failed to evidence the agency provided HHA services from 2/5/16 through 3/29/16 due to lack of available staff, and failed to evidence the agency discharged the patient when it was unable to find staff from 2/5-3/27/15. A. During interview on 4/5/16 at 2:00 PM, the Alternate Administrator stated the agency provided HHA services last week for patient #2, but this was the first time since 2/4 when employee K was pulled from the case. The Alternate Administrator stated this patient is currently receiving physical therapy services as of 4/4/16, through Lutheran which is another Medicare provider, so HHA services here through Medicaid are on hold. B. During interview on 4/5/16 at 2:00 PM, the Administrative Officer stated for waiver patients, a 30 day discharge notice is required. C. During interview on 4/11/16 at 10:45 AM, the Alternate Administrator stated the agency had been providing		plan includes a multi-faceted approach directed byAgency Recruiters. This approach includesjob postings to identify new candidates, previous candidate follow-up viaexisting database, referrals through a renewed emphasis on employee engagement,local community events, and resume database searches. Ongoing monitoring by Clinical Manager/Administratorand AM during weekly office meetings will allow for additional activities andexpansion of current activities where deemed necessary. Office will maintain anactive caregiver Float Pool effective 5/27/16. Office will contract with Maxim Staffing Solutions for potentialutilization of contractual caregiver pool by 5/27/16. **Phase one**: Agency will complete a 100% self-assessmentof the current patient census to determine if patient's needs are being met.This review was completed on 4/21/16 and 5/26/16 and will continue on a monthlybasis during the office monthly Quality Improvement Committee meeting. Ifproblematic areas are identified the Clinical Manager/Administrator/AM willinitiate our multi-faceted approach to narrow down our pool of candidates tothose who possess the skills, meet the availability required to provide ongoingcoverage and are strategically identified based on	

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	wellness checks such as supervisory visits/comprehensive assessments/and recertification visits for the patient since they have been unable to staff a HHA since 2/4/16 until the end of March. The Alternate Administrator stated the agency has also not been able to have any nurses replace and cover HHA shifts due to lack of nurses availability. The Alternate Administrator stated the agency wrote an order to place HHA services on hold as of 3/31/16. The Alternate Administrator stated the patient's significant other has been providing care for the patient before work, at lunch, and after work. The Alternate Administrator stated that Maxim has been attempting recruiting efforts since 2/4/16, and that Aging and In-Home Services is looking for another home health agency for the patient. D. During interview on 4/18/16 at 9:15 AM, the Administrator stated she tried to get patient # 2 discharged due to not having staff available to provide care, but the advisory services of Maxim said not to discharge yet, attempt to find staff. The Administrator stated this patient is being moved to personal care only services, as the patient ended up telling them things that were not true, and the patient can do more for self than the agency was lead to believe, and the patient stated their significant other is		geographical location fromthe patient's home. **Phase two** of the plan is ongoing activity related torecruitment of caregivers. This ongoing plan is managed by expectationsof frequency related to activity. Agency Recruiters are responsible forrecruiting float pool caregivers, creating new job postings, following up withexisting candidates, engaging with current employees to offer additional workopportunities to those who desire more hours, participate in local communityhealth related job fairs, contacting contracted staffing agencies and sourcecurrent resumes in our resume database. AM and/or designee carefully monitoractivity on a daily, weekly and monthly basis to ensure that activity standardsare met to support personnel needs. In addition to the Recruitment plan the Administrator andAccounts Manager/designee will implement daily meetings including "Red Zone" and"Wednesday Clear" to identify areas of concern and activity surroundingrecruitment and staffing issues as evidenced by weekly meeting minutes. "Red Zone" is a daily meeting that occurs toidentify priorities and action items within the office and to ensure that theassociated team members have plans to address, complete, and follow up within atimely manner. "Wednesday Clear" is aproactive communication and planning	

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	able to help the patient. The Administrator stated Maxim has processes in place that have to be followed first, and that she cannot just do what needs to be done without checking first. The Administrator stated discharge is a last resort if we cannot find staff in to service a client. The Administrator stated patient #2 had said a company in New Haven was able to provide services in March, but the patient said no, as the patient requested to stay with Maxim. E. The clinical record failed to evidence the agency provided HHA services since 2/4/16. 1. Missed Visit/Shift Notifications were completed for: 2/5, 2/15, and 2/17/16, with reason "Declined Qualified Caregiver;" Client/Facility loggings failed to evidence the agency had found staff to cover these dates. 2. Missed Visit/Shift Notifications were completed for: 2/8, 2/10, 2/11, 2/12, 2/13, 2/22, 2/24, 2/26, 2/29, 3/2, 3/4, 3/7, 3/9, 3/11, 3/14, 3/16, and 3/18/16 with reason "employee availability." Client/Facility loggings failed to evidence the agency had found staff to cover these dates. 3. The Client/Facility logging		process to identify any staffingconcern(s) and/or open visit/ shifts 10 days in advance, and then to developspecific action plan(s) to meet the patient needs, cover any open visit/ shift,and then to communicate with the patient and/or PCG in a timely manner. An office process will be developed, based on the currentDischarge Policy, in order to ensure that patient discharge will be initiatedwhen one or more discharge criteria is met per Company policy, includingongoing failure to substantially meet staffing requirements per physicianorders. In the event that we experience ongoing failure of our efforts tosubstantially meet a patient's scheduling needs, and available staff cannot beidentified, Agency will commence the discharge process. All internal officestaff will be educated on the new process, including existing Company Policy titled"Discharge" #MD-CL-013.9. The ClinicalManager/Account Manager/Designee will provide this education with attendanceacknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that the agency has adequately met Patient	

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	dated 3/9/16 at 11:25 AM, stated "Informed [nurse from Dr. office] client's recertification ends 4/14/16 and if we are unable to provide staff by then, more than likely we will have to discharge. Informed her of recruiting efforts, and case manager is aware and is attempting to find client a different home care agency that is able to provide staff in the ... area." The record failed to evidence the agency had found staff to cover and failed to evidence the agency planned to discharge before 4/14/16. 4. The Client/Facility logging dated 3/22/16 at 1:45 PM was a note by the Administrator, who had made a visit to the patient. This note stated "3/18/16 ... When asked how [patient] was able to shower and get dressed, client stated [patient] gets up at 5 am with [significant other] before [significant other] goes to work and [significant other] helps [patient] shower and get dressed. During the visit, observed client walking to the bathroom. ... Client was able to use the bathroom alone without assistance. When asked how [patient] was able to get [their] meals during the day, client replied that [significant other] comes home on lunch every day to let the dog outside and will ask ... if [patient] needs anything. If [patient] gets hungry before or after [significant other] lunch break,		staffingneeds and ensure compliance with Company Discharge Policy. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur. Completion Date: 5/27/16	

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	client states [patient] is able to prepare [self] canned soup and heat it up in the microwave. [Patient] also states [patient] is able to make [self] a sandwich." This logging failed to evidence discussion of possible discharge. 5. The Client/Facility logging dated 3/22/16 at 11:15 AM stated "Spoke with client's case manager. She stated she found a home care agency to take over. The company is Acti-Kare and services will begin 4/1/16. There is a possibility client will be discharged tomorrow. ... [Aging and In-Home Case Manager] is still trying to find a PA approved company that will provide the services. She stated she may have to increase client Attendant care to accommodate for therapy. Clarified we are still unable to staff permanently." The record failed to evidence the agency discharged the patient. 6. An email dated 3/23/16 from employee P to Ft. Wayne HH stated "[Patient] told me on the phone that [they] would like to stay on board with us and not change companies. I told [patient] that we have someone coming in from the [patient town] area but that I couldn't make any promises on whether or not the worker could staff [patient] and that I wouldn't know until after the			

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	interview. [Patient] said that [they] didn't care and that [they] wanted to stay on board with us." The record failed to evidence the agency followed its own discharge policy. 5. The agency's policy titled "Discharge," # MD-CL-013.9, dated 1/11/16 stated "5. Discharge Criteria: 5.1. Services will be discontinued when the patient/client meets one (1) or more of the following discharge criteria: ... 5.1.6. Available resources, services, or personnel are inadequate for the continuing needs of the patient/client."			
G 0133 Bldg. 00	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. Based on document review and interview, the agency failed to ensure the administrator was allowed to run the day-to-day operations for 1 of 1 agency. Findings include	G 0133	Governing Body members, which includes the Administrator,will meet to review the Administrator's Job description to include theAdministrator's responsibility for organizing and directing the agency'songoing functions. This	05/19/2016

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	1. The record for patient # 2 was reviewed on 4/5/16. The start of care date was 12/18/15. The record contained a plan of care dated 12/17/15-2/14/16 with orders for HHA 3-5 days per week, 7 to 10 hours per week, for 60 days, plus 18 hours a month Attendant care, and 15 hours per month of Homemaker via waiver. The record failed to evidence the agency provided HHA services from 2/5/16 through 3/29/16 due to lack of available staff, and failed to evidence the agency discharged the patient when it was unable to find staff from 2/5-3/29/15. A. During interview on 4/5/16 at 2:00 PM, the Alternate Administrator stated the agency provided HHA services last week for patient #2, but this was the first time since 2/4 when employee K was pulled from the case. The Alternate Administrator stated this patient is currently receiving physical therapy services as of 4/4/16, through Lutheran which is another Medicare provider, so HHA services here through Medicaid are on hold. B. During interview on 4/5/16 at 2:00 PM, the Administrative Officer stated for waiver patients, a 30 day discharge notice is required.		meeting will bedocumented and meeting minutes maintained in the Governing Body Binder. Ongoing the Governing Body will ensure thatthe Administrator, who is also the Clinical Manager, runs the day to dayoperations of the agency. To ensure this alleged deficiency does not recur, theGoverning Body will meet annually, at minimum, to review the Administrator'sJob Description as well as ensure adherence to overall responsibilities. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur.	

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	C. During interview on 4/18/16 at 9:15 AM, the Administrator stated she tried to get patient # 2 discharged due to not having staff available to provide care, but the advisory services of Maxim said not to discharge yet, attempt to find staff. The Administrator stated this patient is being moved to personal care only services, as the patient ended up telling them things that were not true, and the patient can do more for self than the agency was lead to believe, and the patient stated their significant other is able to help the patient. The Administrator stated Maxim has processes in place that have to be followed first, and that she cannot just do what needs to be done without checking first. The Administrator stated discharge is a last resort if we cannot find staff in to service a client. The Administrator stated patient #2 had said a company in New Haven was able to provide services in March, but the patient said no, as the patient requested to stay with Maxim. 2. The agency's job description titled "Administrator," dated 10/18/2012 stated "The Administrator is appointed by the Governing Body to assume responsibility and accountability for maintaining and directing the ongoing functions of the Home Health Agency. The Administrator is responsible for the			

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	overall management of the business affairs of the agency and ensures initial and ongoing compliance with all applicable Federal, State, and local regulations, Company policies and procedures. ... Essential Duties and Responsibilities: ... 2. Adheres to company Policies and Procedures ... 14. Collaborates with office management to ensure compliant management of patient care from referral through discharge ... Compliance & Ethics Expectations: Participates and successfully completes the Company's compliance program requirements and adheres to ... applicable federal and state requirements."			
G 0156 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on document review and interview, the agency failed to adequately meet the needs of 1 patient for 54 days due to lack of available staffing and failed to discharge the patient per policy (See G 157); failed to ensure home health aide visits were made as ordered by the physician and failed to ensure the home health aide followed physician orders for 1 of 4 records reviewed receiving home health aide services; and failed to ensure orders for treatment were followed by the nurses for 1 of 10 records reviewed (See G 158); failed to ensure the plans of care	G 0156	See response for: G157, G158, G159 and G165	05/19/2016

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	included all durable medical equipment used by the patients for 1 of 5 observations (See G 159); and failed to ensure the physician orders for treatment were followed by the nurses for 1 of 10 records reviewed (See G 165). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.18 Acceptance of Patients, Plan of Care & Medical Supervision.			
G 0157 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Based on document review and interview, the agency failed to adequately meet the needs of 1 patient for 54 days due to lack of available staffing and failed to discharge the patient per policy. (#2) Findings include 1. The record for patient # 2 was	G 0157	Patient #2 was discharged on 4/14/16. In order to ensure that patient staffing needs are being metthe Administrator has put measures in place to include routine review ofpatient census through daily “Red Zone” meetings, weekly “Wednesday Clear”program, and monthly Quality Improvement Committee meetings all of which areexplained in the plan below.	05/27/2016

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	reviewed on 4/5/16. The start of care date was 12/18/15. The record contained a plan of care dated 12/17/15-2/14/16 with orders for HHA 3-5 days per week, 7 to 10 hours per week, for 60 days, plus 18 hours a month Attendant care, and 15 hours per month of Homemaker via waiver. The record failed to evidence the agency provided HHA services from 2/5/16 through 3/29/16 due to lack of available staff, and failed to evidence the agency discharged the patient when it was unable to find staff from 2/5-3/27/15. A. During interview on 4/5/16 at 2:00 PM, the Alternate Administrator stated the agency provided HHA services last week for patient #2, but this was the first time since 2/4 when employee K was pulled from the case. The Alternate Administrator stated this patient is currently receiving physical therapy services as of 4/4/16, through Lutheran which is another Medicare provider, so HHA services here through Medicaid are on hold. B. During interview on 4/5/16 at 2:00 PM, the Administrative Officer stated for waiver patients, a 30 day discharge notice is required. C. During interview on 4/11/16 at 10:45 AM, the Alternate Administrator		Additionally, the Administrator will implement the followingaction items: 1. Implementa caregiver "Float Pool" program a. For the express purpose of coveringopen shifts related to staff cancellations, vacations, or other reasons causingopen shifts, excluding client refusal of available, competent staff. b. Ideal candidates will have therequisite level of experience to meet the patient's care needs/ requirementsand committed availability. 2. Implementcontractual agreements with Maxim Staffing Solutions a. Forthe express purpose of covering open shifts related to staff cancellations,vacations, or other reasons causing open shifts, excluding client refusal ofavailable, competent staff when all other options have been exhausted. The current patient census was reviewed on 4/21/16 and againon 5/26/16 to determine if patient staffing needs are being met. This patient census review will be completed atminimum on a monthly ongoing basis as part of the office Quality ImprovementCommittee meeting. Documentation of thisreview will be maintained in the Quality Improvement Binder. When problematicstaffing areas are identified, the office will adhere to the following process forthose	

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	stated the agency had been providing wellness checks such as supervisory visits/comprehensive assessments/and recertification visits for the patient since they have been unable to staff a HHA since 2/4/16 until the end of March. The Alternate Administrator stated the agency has also not been able to have any nurses replace and cover HHA shifts due to lack of nurses availability. The Alternate Administrator stated the agency wrote an order to place HHA services on hold as of 3/31/16. The Alternate Administrator stated the patient's significant other has been providing care for the patient before work, at lunch, and after work. The Alternate Administrator stated that Maxim has been attempting recruiting efforts since 2/4/16, and that Aging and In-Home Services is looking for another home health agency for the patient. D. During interview on 4/18/16 at 9:15 AM, the Administrator stated she tried to get patient # 2 discharged due to not having staff available to provide care, but the advisory services of Maxim said not to discharge yet, attempt to find staff. The Administrator stated this patient is being moved to personal care only services, as the patient ended up telling them things that were not true, and the patient can do more for self than the agency was lead to believe, and the		patients who are at risk of needs not being met: ·Recruiters will call all primary and secondarydirect caregivers to check their availability to meet the staffing requirementper the patient's plan of care. If theprimary and secondary caregivers are unavailable, qualified staff will beidentified from current caregiver roster, to include float pool staff andcontracted workers as explained below, and reviewed with the patient andprimary caregiver as an option to meet staffing need; if acceptable, the newstaff will receive a patient specific orientation from the ClinicalSupervisor/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. ·A caregiver float pool program will be developedby 5/27/16 as a tertiary option to fill patient staffing needs. Float pool staff will be available for calloffs and other staffing gaps on an as needed basis. Float pool staff will only be utilized tocover patients for which they are qualified. Float pool staff will receive a patient specific orientation from theClinical Supervisor/clinical designee prior to working the	

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	patient stated their significant other is able to help the patient. The Administrator stated Maxim has processes in place that have to be followed first, and that she cannot just do what needs to be done without checking first. The Administrator stated discharge is a last resort if we cannot find staff in to service a client. The Administrator stated patient #2 had said a company in New Haven was able to provide services in March, but the patient said no, as the patient requested to stay with Maxim. E. The clinical record failed to evidence the agency provided HHA services since 2/4/16. 1. Missed Visit/Shift Notifications were completed for: 2/5, 2/15, and 2/17/16, with reason "Declined Qualified Caregiver;" Client/Facility loggings failed to evidence the agency had found staff to cover these dates. 2. Missed Visit/Shift Notifications were completed for: 2/8, 2/10, 2/11, 2/12, 2/13, 2/22, 2/24, 2/26, 2/29, 3/2, 3/4, 3/7, 3/9, 3/11, 3/14, 3/16, and 3/18/16 with reason "employee availability." Client/Facility loggings failed to evidence the agency had found staff to cover these dates.		shift. ·Measures have been taken by the Administrator toensure a contractual agreement with Maxim Staffing Solutions to assist withproviding a qualified caregiver in the event an open shift cannot be filled bythe Home Health Agency's own employee pool. If no staff is available, to include primary, secondary, tertiary andfloat pool, the agency will notify contracted agency for staffing options. If no staff available, the patient, primarycaregiver, physician and patient's case manager are notified and alternateforms of care are discussed. Allcommunications will be recorded in the system of record. If it is identified that staffing unavailabilitywill not be intermittent but long term, then there will be increasedrecruitment efforts as identified in the recruitment strategy outlined later inthis response. ·If these increased efforts to staff the patientper the physician ordered frequency are not effective, then we will refer tothe discharge policy as we will have met one of the criteria for discharge thatstates available personnel are not adequate for the continuing needs of theclient. ·Internal Office staff will be educated on thisprocess by 5/27/16. The DOCS/AM/Designeewill provide this education with attendance	

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	3. The Client/Facility logging dated 3/9/16 at 11:25 AM, stated "Informed [nurse from Dr. office] client's recertification ends 4/14/16 and if we are unable to provide staff by then, more than likely we will have to discharge. Informed her of recruiting efforts, and case manager is aware and is attempting to find client a different home care agency that is able to provide staff in the ... area." The record failed to evidence the agency had found staff to cover and failed to evidence the agency planned to discharge before 4/14/16. 4. The Client/Facility logging dated 3/22/16 at 1:45 PM was a note by the Administrator, who had made a visit to the patient. This note stated "3/18/16 ... When asked how [patient] was able to shower and get dressed, client stated [patient] gets up at 5 am with [significant other] before [significant other] goes to work and [significant other] helps [patient] shower and get dressed. During the visit, observed client walking to the bathroom. ... Client was able to use the bathroom alone without assistance. When asked how [patient] was able to get [their] meals during the day, client replied that [significant other] comes home on lunch every day to let the dog outside and will ask ... if [patient] needs anything. If [patient] gets hungry before		acknowledgment and respectivedocuments to be kept in the QI Binder. An office intake process has been developed based on companypolicy titled “Acceptance and Admission” MD-CL-006.3 This process includes steps to ensure thatpatients are not accepted into service without the resources available toprovide care. During the intake processthe office referral team will evaluate all new referrals for staffing needs anda schedule of available, qualified caregivers is identified prior to acceptingthe patient for admission. The patientwould not be accepted for admission if not 100% staffed per the physicianordered frequency. Further, during theintake process, a review of all current patients with similar services andgeographic location will be reviewed to ensure that admission of the newpatient would not adversely affect staffing options for current patient. If itis identified that current patients with similar services an geographiclocation will be at risk for staffing gaps, the new patient referral will bedeclined. Internal Office staff will be educated on this process by5/27/16. The DOCS/AM/Designee willprovide this education with attendance acknowledgment and respective documentsto be kept in the QI Binder. An office process will be developed, based on the currentMissed Shift	

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	or after [significant other] lunch break, client states [patient] is able to prepare [self] canned soup and heat it up in the microwave. [Patient] also states [patient] is able to make [self] a sandwich." This logging failed to evidence discussion of possible discharge. 5. The Client/Facility logging dated 3/22/16 at 11:15 AM stated "Spoke with client's case manager. She stated she found a home care agency to take over. The company is Acti-Kare and services will begin 4/1/16. There is a possibility client will be discharged tomorrow. ... [Aging and In-Home Case Manager] is still trying to find a PA approved company that will provide the services. She stated she may have to increase client Attendant care to accommodate for therapy. Clarified we are still unable to staff permanently." The record failed to evidence the agency discharged the patient. 6. An email dated 3/23/16 from employee P to Ft. Wayne HH stated "[Patient] told me on the phone that [they] would like to stay on board with us and not change companies. I told [patient] that we have someone coming in from the [patient town] area but that I couldn't make any promises on whether or not the worker could staff [patient] and		Policy, in order to ensure that all missed shifts are documentedand supportive loggings will be entered. All internal office staff will be educated on the new process, includingexisting Missed Shifts Policy. The DOCS/AM/Designee will provide this educationwith attendance acknowledgment and respective documents to be kept in the QIBinder. To be completed by5/17/2016. In order to minimize the future recurrence of missed shifts,the Administrator/Clinical Manager and Accounts Manager/designee will implementand monitor a Recruitment Plan. Allinternal staff will be educated on this plan by Accounts Manager/designee withattendance acknowledgement and respective documents to be kept in the QIbinder. **Recruitment Plan:** Our recruitment plan includes a multi-faceted approach directed byAgency Recruiters. This approachincludes job postings to identify new candidates, previous candidate follow-upvia existing database, referrals through a renewed emphasis on employeeengagement, local community events, and resume database searches. Ongoing monitoring by Clinical Manager/Administratorand AM during weekly office meetings will allow for additional activities andexpansion of current activities where deemed necessary. Office will	

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	that I wouldn't know until after the interview. [Patient] said that [they] didn't care and that [they] wanted to stay on board with us." The record failed to evidence the agency followed its own discharge policy. 2. The agency's policy titled "Discharge," # MD-CL-013.9, dated 1/11/16 stated "5. Discharge Criteria: 5.1. Services will be discontinued when the patient/client meets one (1) or more of the following discharge criteria: ... 5.1.6. Available resources, services, or personnel are inadequate for the continuing needs of the patient/client."		maintain anactive caregiver Float Pool effective 5/27/16. Office will contract with Maxim Staffing Solutions for potential utilizationof contractual caregiver pool by 5/27/16. **Phase one**: Agency will complete a 100% self-assessmentof the current patient census to determine if patient's needs are being met. Thisreview was completed on April 21, 2016 and May 26, 2016 and will continue on amonthly basis during the office monthly Quality Improvement Committee meeting.If problematic areas are identified the Clinical Manager/Administrator/AM willinitiate our multi-faceted approach to narrow down our pool of candidates tothose who possess the skills, meet the availability required to provide ongoingcoverage and are strategically identified based on geographical location fromthe patient's home. **Phase two** of the plan is ongoing activity related torecruitment of caregivers. This ongoing plan is managed by expectationsof frequency related to activity. Agency Recruiters are responsible for recruitingfloat pool caregivers, creating new job postings, following up with existingcandidates, engaging with current employees to offer additional workopportunities to those who desire more hours, participate in local communityhealth related job fairs, contacting	

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			contracted staffing agencies and sourcecurrent resumes in our resume database. AM and/or designee carefullymonitor activity on a daily, weekly and monthly basis to ensure that activitystandards are met to support personnel needs. In addition to the Recruitment plan the Administrator andAccounts Manager/designee will implement the daily “Red Zone” meeting and weekly“Wednesday Clear” program to identify areas of concern and activity surroundingrecruitment and staffing issues as evidenced by meeting minutes. “Red Zone” is a daily meeting that occurs toidentify priorities and action items within the office and to ensure that theassociated team members have plans to address, complete, and follow up within atimely manner. “Wednesday Clear” is aproactive communication and planning process to identify any staffingconcern(s) and/or open visit/ shifts 10 days in advance, and then to developspecific action plan(s) to meet the patient needs, cover any open visit/ shift,and then to communicate with the patient and/or primary caregiver in a timelymanner. An office process will be developed, based on the currentDischarge Policy, in order to ensure that patient discharge will be initiatedwhen one or more discharge criteria is met per Company policy, includingongoing	

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			failure to substantially meet staffing requirements per physicianorders. In the event that we experience ongoing failure of our efforts tosubstantially meet a patient's scheduling needs, and available staff cannot beidentified, Agency will commence the discharge process. All internal officestaff will be educated on the new process, including existing Company Policy titled"Discharge" #MD-CL-013.9. The ClinicalManager/Account Manager/Designee will provide this education with attendanceacknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that the agency has adequately met Patient staffingneeds and ensure compliance with Company Discharge Policy. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur. Completion Date: 5/27/16	
G 0158 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a			

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	doctor of medicine, osteopathy, or podiatric medicine. Based on document review and interview, the agency failed to ensure home health aide visits were made as ordered by the physician and failed to ensure the home health aide followed physician orders for 1 of 4 records reviewed (# 2) receiving home health aide services; and failed to ensure orders for treatment were followed by the nurses for 1 of 10 records reviewed. (# 4) Findings include 1. The record for patient # 2 was reviewed on 4/5/16. The start of care date was 12/18/15. The record contained a plan of care dated 12/17/15-2/14/16 with orders for HHA 3-5 days per week, 7 to 10 hours per week, for 60 days, plus 18 hours a month Attendant care, and 15 hours per month of Homemaker via waiver; HHA to check blood pressure and pulse daily and notify Clinical Supervisor if outside parameters- blood pressure to be no greater than 150/100 and not less than 100/60, Pulse to be no greater than 130 and no less than 70. The record failed to evidence the agency provided HHA services from 2/5/16 through 3/29/16 due to lack of available staff; failed to evidence the agency discharged the patient when it was unable	G 0158	Patient #2 was discharged on 4/14/2016. Employee R wasre-educated on following the plan of care on 5/11/2016. An office process will be developed, based on the currentMissed Shift Policy, in order to ensure that all missed shifts are documentedand supportive loggings will be entered. All internal office staff will be educated on the new process, includingexisting Missed Shifts Policy. The DOCS/AM/Designee will provide this educationwith attendance acknowledgment and respective documents to be kept in the QIBinder. To be completed by 5/17/2016. The current patient census was reviewed on 4/21/16 and againon 5/26/16 to determine if patient staffing needs are being met. This patient census review will be completedon a monthly ongoing basis as part of the office Quality Improvement Committeemeeting. Documentation of this reviewwill be maintained in the Quality Improvement Binder. When problematic staffingareas are identified, the office will adhere to the following process for thosepatients who are at risk of needs not being met: ·Recruiters will call all primary and secondarydirect caregivers to check their availability to meet the staffing requirementper the patient's plan of care. If	05/27/2016

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	to find staff from 2/5-3/27/15; and failed to evidence the HHA followed the plan of care as ordered. A. During interview on 4/5/16 at 2:00 PM, the Alternate Administrator stated the agency provided HHA services last week for patient #2, but this was the first time since 2/4 when employee K was pulled from the case. The Alternate Administrator stated this patient is currently receiving physical therapy services as of 4/4/16, through Lutheran which is another Medicare provider, so HHA services here through Medicaid are on hold. B. During interview on 4/5/16 at 2:00 PM, the Administrative Officer stated for waiver patients, a 30 day discharge notice is required. C. During interview on 4/11/16 at 10:45 AM, the Alternate Administrator stated the agency had been providing wellness checks such as supervisory visits/comprehensive assessments/and recertification visits for the patient since they have been unable to staff a HHA since 2/4/16 until the end of March. The Alternate Administrator stated the agency has also not been able to have any nurses replace and cover HHA shifts due to lack of nurses availability. The Alternate		theprimary and secondary caregivers are unavailable, qualified staff will beidentified from current caregiver roster, to include float pool staff andcontracted workers as explained below, and reviewed with the patient andprimary caregiver as an option to meet staffing need; if acceptable, the newstaff will receive a patient specific orientation from the ClinicalSupervisor/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. ·A caregiver float pool will be developed by5/27/16 as a tertiary option to fill patient staffing needs. Float pool staff will be available for calloffs and other staffing gaps on an as needed basis. Float pool staff will only be utilized tocover patients for which they are qualified. Float pool staff will receive a patient specific orientation from theClinical Supervisor/clinical designee prior to working the shift. ·Measures have been taken by the Administrator toensure a contractual agreement with Maxim Staffing Solutions to assist withproviding a qualified caregiver in the event an open shift cannot be filled bythe Home Health	

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	Administrator stated the agency wrote an order to place HHA services on hold as of 3/31/16. The Alternate Administrator stated the patient's significant other has been providing care for the patient before work, at lunch, and after work. The Alternate Administrator stated that Maxim has been attempting recruiting efforts since 2/4/16, and that Aging and In-Home Services is looking for another home health agency for the patient. D. During interview on 4/18/16 at 9:15 AM, the Administrator stated she tried to get patient # 2 discharged due to not having staff available to provide care, but the advisory services of Maxim said not to discharge yet, attempt to find staff. The Administrator stated this patient is being moved to personal care only services, as the patient ended up telling them things that were not true, and the patient can do more for self than the agency was lead to believe, and the patient stated their significant other is able to help the patient. The Administrator stated Maxim has processes in place that have to be followed first, and that she cannot just do what needs to be done without checking first. The Administrator stated discharge is a last resort if we cannot find staff in to service a client. The Administrator stated patient #2 had said a company in New		Agency's own employee pool. If no staff is available, to include primary, secondary, tertiary andfloat pool, the agency will notify contracted agency for staffing options. If no staff available, the patient, primarycaregiver, physician and patient's casemanager are notified and alternate forms of care are discussed. All communications will be recorded in thesystem of record. If it is identifiedthat staffing unavailability will not be intermittent but long term, then therewill be increased recruitment efforts as identified in the recruitment strategyoutlined later in this response. ·If these increased efforts to staff the patientper the physician ordered frequency are not effective, then we will refer tothe discharge policy as we will have met one of the criteria for discharge thatstates available personnel are adequate for the continuing needs of theclient. ·The Administrator/designee will educate allInternal Office staff on this process by 5/27/16. This education will be maintained in theQuality Improvement binder. An office intake process has been developed based on companypolicy titled "Acceptance and Admission" MD-CL-006.3 This process includes steps to ensure thatpatients are not accepted into service without the resources available toprovide	

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	Haven was able to provide services in March, but the patient said no, as the patient requested to stay with Maxim. E. The clinical record failed to evidence the agency provided HHA services since 2/4/16. 1. Missed Visit/Shift Notifications were completed for: 2/5, 2/15, and 2/17/16, with reason "Declined Qualified Caregiver;" Client/Facility loggings failed to evidence the agency had found staff to cover these dates. 2. Missed Visit/Shift Notifications were completed for: 2/8, 2/10, 2/11, 2/12, 2/13, 2/22, 2/24, 2/26, 2/29, 3/2, 3/4, 3/7, 3/9, 3/11, 3/14, 3/16, and 3/18/16 with reason "employee availability." Client/Facility loggings failed to evidence the agency had found staff to cover these dates. 3. The Client/Facility logging dated 3/9/16 at 11:25 AM, stated "Informed [nurse from Dr. office] client's recertification ends 4/14/16 and if we are unable to provide staff by then, more than likely we will have to discharge. Informed her of recruiting efforts, and case manager is aware and is attempting to find client a different home care agency that is able to provide staff in the		care. During the intake processthe office referral team will evaluate all new referrals for staffing needs anda schedule of available, qualified caregivers is identified prior to acceptingthe patient for admission. The patientwould not be accepted for admission if not 100% staffed per the physicianordered frequency. Further, during theintake process, a review of all current patients with similar services andgeographic location will be reviewed to ensure that admission of the new patientwould not adversely affect staffing options for current patient. If it isidentified that current patients with similar services an geographic locationwill be at risk for staffing gaps, the new patient referral will bedeclined. The Administrator/designee will educate all Internal Officestaff on this process by 5/27/16. Thiseducation will be maintained in the Quality Improvement binder. An office process will be developed, based on the currentMissed Shift Policy, in order to ensure that all missed shifts are documentedand supportive loggings will be entered. All internal office staff will be educated on the new process, includingexisting Missed Shifts Policy. The DOCS/AM/Designee will provide this educationwith attendance acknowledgment and respective	

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	... area." The record failed to evidence the agency had found staff to cover and failed to evidence the agency planned to discharge before 4/14/16. 4. The Client/Facility logging dated 3/22/16 at 1:45 PM was a note by the Administrator, who had made a visit to the patient. This note stated "3/18/16 ... When asked how [patient] was able to shower and get dressed, client stated [patient] gets up at 5 am with [significant other] before [significant other] goes to work and [significant other] helps [patient] shower and get dressed. During the visit, observed client walking to the bathroom. ... Client was able to use the bathroom alone without assistance. When asked how [patient] was able to get [their] meals during the day, client replied that [significant other] comes home on lunch every day to let the dog outside and will ask ... if [patient] needs anything. If [patient] gets hungry before or after [significant other] lunch break, client states [patient] is able to prepare [self] canned soup and heat it up in the microwave. [Patient] also states [patient] is able to make [self] a sandwich." This logging failed to evidence discussion of possible discharge. 5. The Client/Facility logging dated 3/22/16 at 11:15 AM stated "Spoke		documents to be kept in the QI Binder. To be completed by 5/17/2016. In order to minimize the future recurrence of missed shifts,the Administrator/Clinical Manager and Accounts Manager/designee will implementand monitor a Recruitment Plan. All internal staff will be educated on this planby Accounts Manager/designee with attendance acknowledgement and respectivedocuments to be kept in the QI binder. **Recruitment Plan:** Our recruitment plan includes a multi-faceted approach directed byAgency Recruiters. This approachincludes job postings to identify new candidates, previous candidate follow-upvia existing database, referrals through a renewed emphasis on employeeengagement, local community events, and resume database searches. Ongoing monitoring by ClinicalManager/Administrator and AM during weekly office meetings will allow foradditional activities and expansion of current activities where deemednecessary. Office will maintain an active caregiver Float Pool effective5/27/16. Office will contract with MaximStaffing Solutions for potential utilization of contractual caregiver pool by5/27/16. **Phase one**: Agency will complete a 100% self-assessmentof the current patient census to determine if	

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	with client's case manager. She stated she found a home care agency to take over. The company is Acti-Kare and services will begin 4/1/16. There is a possibility client will be discharged tomorrow. ... [Aging and In-Home Case Manager] is still trying to find a PA approved company that will provide the services. She stated she may have to increase client Attendant care to accommodate for therapy. Clarified we are still unable to staff permanently." The record failed to evidence the agency discharged the patient. 6. An email dated 3/23/16 from employee P to Ft. Wayne HH stated "[Patient] told me on the phone that [they] would like to stay on board with us and not change companies. I told [patient] that we have someone coming in from the [patient town] area but that I couldn't make any promises on whether or not the worker could staff [patient] and that I wouldn't know until after the interview. [Patient] said that [they] didn't care and that [they] wanted to stay on board with us." The record failed to evidence the agency followed its own discharge policy. 7. The Aide Weekly Note dated 3/28/16 by employee R, failed to evidence the HHA checked the patient's		patient's needs are being met.This review was completed on 4/21/2016 and 5/26/2016 and will continueon a monthly basis during the office monthly Quality Improvement Committeemeeting. If problematic areas are identified the ClinicalManager/Administrator/AM will initiate our multi-faceted approach to narrowdown our pool of candidates to those who possess the skills, meet theavailability required to provide ongoing coverage and are strategicallyidentified based on geographical location from the patient's home. **Phase two** of the plan is ongoing activity related torecruitment of caregivers. This ongoing plan is managed by expectationsof frequency related to activity. Agency Recruiters are responsible forrecruiting float pool caregivers, creating new job postings, following up withexisting candidates, engaging with current employees to offer additional workopportunities to those who desire more hours, participate in local communityhealth related job fairs, contacting contracted staffing agencies and sourcecurrent resumes in our resume database. AM and/or designee carefully monitoractivity on a daily, weekly and monthly basis to ensure that activity standardsare met to support personnel needs. In addition to the Recruitment plan the Administrator andAccounts	

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	blood pressure. 2. The record for patient # 4 was reviewed on 4/12/16. The start of care for patient # 4 was 10/5/09. The Plan of care dated 3/2-4/30/16 contained orders for skilled nursing SN 4-6 days per week, 26-43 hours per week for 60 days. SN orders included flush g-tube with up to 250 mL [milliliters] of water as needed, before and after medications and as needed per clogged tube. The record failed to evidence the nurses followed the water orders. A. The Nursing Flow Sheet dated 3/2/16 Intake section evidenced the nurse documented 350 cc [cubic centimeters] flush at 12:10 PM. B. The Nursing Flow Sheet dated 3/4/16 Intake section evidenced the nurse documented 350 cc flushes at 1:00 and 6:45 PM. C. The Nursing Flow Sheet dated 3/9/16 Intake section evidenced the nurse documented 350 cc flush at 1:00 PM. D. The Nursing Flow Sheet dated 3/11/16 Intake section evidenced the nurse documented 350 cc flushes at 11:05 AM, 1:00 PM, and 300 cc flush at 2:15 PM.		Manager/designee will implement daily meetings including “Red Zone”and “Wednesday Clear” to identify areas of concern and activity surroundingrecruitment and staffing issues as evidenced by weekly meeting minutes. “Red Zone” is a daily meeting that occurs toidentify priorities and action items within the office and to ensure that theassociated team members have plans to address, complete, and follow up within atimely manner. “Wednesday Clear” is aproactive communication and planning process to identify any staffingconcern(s) and/or open visit/ shifts 10 days in advance, and then to developspecific action plan(s) to meet the patient needs, cover any open visit/ shift,and then to communicate with the patient and/or PCG in a timely manner. An office process will be developed, based on the currentDischarge Policy, in order to ensure that patient discharge will be initiatedwhen one or more discharge criteria is met per Company policy, includingongoing failure to substantially meet staffing requirements per physicianorders. In the event that we experience ongoing failure of our efforts tosubstantially meet a patient’s scheduling needs, and available staff cannot beidentified, Agency will commence the discharge process. All internal officestaff will be educated on the	

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	E. The Nursing Flow Sheet dated 3/12/16 Intake section evidenced the nurse documented 350 cc flush at 11:10 AM. F. The Nursing Flow Sheet dated 3/13/16 Intake section evidenced the nurse documented 350 cc flushes at 11:20 AM and 12:40 PM. G. The Nursing Flow Sheet dated 3/14/16 Intake section evidenced the nurse documented 350 cc flushes at 11:15 AM and 2:15 PM. H. The Nursing Flow Sheet dated 3/15/16 Intake section evidenced the nurse documented 350 cc flushes at 11:30 AM and 12:50 PM, and a 300 cc flush at 2:05 PM. I. The Nursing Flow Sheet dated 3/15/16 Intake section evidenced the nurse documented 350 cc flushes at 11:00 AM and 12:30 PM, and a 300 cc flush at 2:00 PM. J. The Nursing Flow Sheet dated 3/18/16 Intake section evidenced the nurse documented 300 cc flush at 2:40 PM. K. The Nursing Flow Sheet dated		new process, including existing Company Policytitled “Discharge” #MD-CL-013.9. TheClinical Manager/Account Manager/Designee will provide this education withattendance acknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that the agency has adequately met Patient staffingneeds and ensure compliance with Company Discharge Policy. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur. Completion Date: 5/27/16 Direct Caregivers for Patient #4 will be re-educated onfollowing physician’s orders, to include water flushes per the plan of care. 100% review of documentation for patient # 4will be performed for 30 days to ensure that all orders for treatment,including water flushes, are followed by the nurses providing care. All skilled nursing staff was assigned Annual ComplianceTraining which includes the importance of documentation and the plan of care,on 5/2/16. Ongoing nurse flowsheets and aide weekly notes for 25% ofthe patient census will	

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	3/19/16 Intake section evidenced the nurse documented 350 cc flushes at 11:40 AM and 12:30 PM. L. The Nursing Flow Sheet dated 3/20/16 Intake section evidenced the nurse documented 350 cc flushes at 11:00 AM and 12:30 PM. M. The Nursing Flow Sheet dated 3/21/16 Intake section evidenced the nurse documented 400 cc flush at 11:10 AM, and 350 cc flush at 12:30 PM. N. The Nursing Flow Sheet dated 3/22/16 Intake section evidenced the nurse documented 400 cc flush at 11:10 AM, and 350 cc flush at 12:30 PM. O. The Nursing Flow Sheet dated 3/23/16 Intake section evidenced the nurse documented 400 cc flush at 11:15 AM, and 350 cc flush at 12:45 PM. P. The Nursing Flow Sheet dated 3/25/16 Intake section evidenced the nurse documented 350 cc flush at 11:00 AM and 12:45 PM. Q. The Nursing Flow Sheet dated 3/27/16 Intake section evidenced the nurse documented 350 cc flush at 11:10 AM and 12:30 PM.		be reviewed weekly by the Clinical Supervisors as apart of focused documentation review to ensure that direct care staff arefollowing physician orders. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that direct caregivers, to include home healthaides, LPNs and RNs, are following the physician orders. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur. Completion Date: 5/19/16 **G156/G159 and N524 G-159 Plan of CareAND N524 410 IAC 17-13-1(a)(1) (PatientCare)** The Clinical Manager will re-educate all Internal Clinical Supervisors,including Employee J, on Company Policy “Home Health Certificate and Plan(s) ofCare” #HH-CL-007.6 to include the requirement to ensure all durable medicalequipment in the home and used by the patient is included on the Plan ofCare. Attendance will be recorded andfiled in the QI Binder along with supporting documentation. To be completed by5/19/2016. A supplemental order for patient #6 adding the appropriatepatient durable medical equipment was obtained and signed by the patient’sphysician on 4/18/16. The Plan of Care forPatient #6	

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	R. The Nursing Flow Sheet dated 3/28/16 Intake section evidenced the nurse documented 350 cc flush at 11:00 AM and 12:35 PM. S. The Nursing Flow Sheet dated 3/29/16 Intake section evidenced the nurse documented 350 cc flush at 11:10 AM and 12:45 PM. T. The Nursing Flow Sheet dated 3/30/16 Intake section evidenced the nurse documented 350 cc flush at 11:00 AM and 12:30 PM. U. The Nursing Flow Sheet dated 4/2/16 Intake section evidenced the nurse documented 350 cc flush at 11:35 AM and 12:50 PM. 3. The agency's job description titled "Registered Nurse," stated "Performance Standards: ... 6. ... Administers medications and treatment as prescribed by the physician." 4. The agency's job description titled "Licensed Vocational Nurse/Licensed Practical Nurse," stated "Performance Standards: 1. Each shift or visit reflects the provision of skilled nursing care rendered in accordance with physician's orders. ... 2. ... b. Performs specific treatments and medication administration		was updated to include the all durable medical equipment used by thepatient. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that all durable medical equipment used by thepatient is included in the plan of care. Additionally a minimum of 5 home visits will be conducted as part of thequarterly audit to ensure that all durable medical equipment in the patient'shome is included on the plan of care. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur. Completion Date: 5/27/16	

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	157591	A. BUILDING 00 B. WING	04/19/2016

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	in accordance with physician orders." 5. The agency's policy titled "Missed Shift/Visit-Delaware Physician Care," # SOP-MD-CL-016 DEa, dated 1/6/2014 stated "1.0 Maintain Adequate Resource Pool, 2.0 Notify Patient and/or Family of Process to Follow in the Event of a Reschedule and/or Staff Failure to Appear, 3.0 Receive Notification That Assigned Staff Unable to Meet and/or Fulfill Scheduled Shift, 4.0 Office Contacts Qualifies Alternate Staff, 5.0 Determine if Available Resources to Cover Shift Are Not Found in the Available Office Pool, 6.0 Determine if Shift is Unable to Be Covered By Alternate Resources, 7.0 Updated Schedule to Missed Shift, 8.0 Transmit Weekly Payroll. ... Comments ... Supplemental resources will be available to address the patient care needs when regularly scheduled staff cannot meet their scheduled shift. ... Office Operations should consider establishing contractual relationships with staffing agencies or alternate home health agencies to provide supplemental qualified staff when employees are not available to cover scheduled and/or unscheduled absences. Qualified administrative and clinical staff will be available to respond to patient and/or Direct Care Staff calls as outlined in			

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	policy: HH-CL-019: On-Call Coverage. ... 2.0 ... Comments, ... The Clinical staff will provide written and verbal notification during the admission visit that gaps in Covered Personnel Care/Attendant Care Services may be filled with a back-up worker. ... 4.0 ... Comments, Consider alternate staffs who are regularly assigned to determine if they are available to cover the open shift. If patient familiar staff is unavailable, expand search to qualified staff which meet qualifications and competencies for the patient. ... 6.0 ... Comments, If all backup options fail to identify a resource, the Office Clinical Leader and physician will be notified through communication and documented in the medical record."			
G 0159	484.18(a) PLAN OF CARE			

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Bldg. 00	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 observation, document review, and interview, the agency failed to ensure the plans of care included all durable medical equipment (DME) used by the patients for 1 of 5 observations. (#6) Findings include 1. The clinical record for patient #6 was reviewed on 4/14/16. The start of care date was 12/11/15. The plan of care dated 4/9-6/7/16 contained orders for HHA 3-5 days per week, 9-15 hours per month for 60 days. The plan of care failed to include all DME used by the patient. A. During observation of patient # 6 on 4/13/16 at 2:00 PM, DME in the home included a life line button and shower chair. The Plan of Care failed to include these DME. B. During interview on 4/14/16 at 1:20 PM, employee J (Alternate Nurse	G 0159	The Clinical Manager will re-educate all Internal Clinical Supervisors,including Employee J, on Company Policy “Home Health Certificate and Plan(s) ofCare” #HH-CL-007.6 to include the requirement to ensure all durable medicalequipment in the home and used by the patient is included on the Plan ofCare. Attendance will be recorded andfiled in the QI Binder along with supporting documentation. To be completed by5/19/2016. A supplemental order for patient #6 adding the appropriatepatient durable medical equipment was obtained and signed by the patient’sphysician on 4/18/16. The Plan of Care forPatient #6 was updated to include the all durable medical equipment used by thepatient. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that all durable medical equipment used by thepatient is included in the plan of care. Additionally a minimum of 5	05/19/2016

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	Supervisor) stated she did not realize the patient had a shower chair. 2. The agency 's policy titled "Home Health Certification and Plan(s) of Care," # HH-CL-007.6, dated 6/22/15 stated "Procedure ... 5.3. The Plan of Care shall include, but not be limited to: ... 5.3.4. Listing of equipment and supplies."		home visits will be conducted as part of thequarterly audit to ensure that all durable medical equipment in the patient'shome is included on the plan of care. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur. To be completed by 5/19/2016	
G 0165 Bldg. 00	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. Based on document review and interview, the agency failed to ensure the physician orders for treatment were followed by the nurses for 1 of 10 records reviewed. (# 4 Findings include 1. The record for patient # 4 was reviewed on 4/12/16. The start of care for patient # 4 was 10/5/09. The Plan of care dated 3/2-4/30/16 contained orders for skilled nursing SN 4-6 days per week, 26-43 hours per week for 60 days. SN orders included flush g-tube with up to 250 mL [milliliters] of water as needed, before and after medications and as needed per clogged tube. The record	G 0165	Direct Caregivers for Patient #4 will be re-educated onfollowing physician's orders, to include water flushes per the plan of care. 100% review of documentation for patient # 4 willbe performed for 30 days to ensure that all orders for treatment, includingwater flushes, are followed by the nurses providing care. All skilled nursing staff was assigned Annual ComplianceTraining which includes the importance of documentation and the plan of care,on 5/2/6. Ongoing Nursing flowsheets for 25% of the patient census willbe reviewed weekly by the Clinical Supervisors as a part of focuseddocumentation review to ensure that direct care staff are following physicianorders. To ensure this alleged deficiency	05/19/2016

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	failed to evidence the nurses followed the water orders. A. The Nursing Flow Sheet dated 3/2/16 Intake section evidenced the nurse documented 350 cc [cubic centimeters] flush at 12:10 PM. B. The Nursing Flow Sheet dated 3/4/16 Intake section evidenced the nurse documented 350 cc flushes at 1:00 and 6:45 PM. C. The Nursing Flow Sheet dated 3/9/16 Intake section evidenced the nurse documented 350 cc flush at 1:00 PM. D. The Nursing Flow Sheet dated 3/11/16 Intake section evidenced the nurse documented 350 cc flushes at 11:05 AM, 1:00 PM, and 300 cc flush at 2:15 PM. E. The Nursing Flow Sheet dated 3/12/16 Intake section evidenced the nurse documented 350 cc flush at 11:10 AM. F. The Nursing Flow Sheet dated 3/13/16 Intake section evidenced the nurse documented 350 cc flushes at 11:20 AM and 12:40 PM. G. The Nursing Flow Sheet dated		does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that direct caregivers, including LPNs and RNs, arefollowing the physician orders. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur.	

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	3/14/16 Intake section evidenced the nurse documented 350 cc flushes at 11:15 AM and 2:15 PM. H. The Nursing Flow Sheet dated 3/15/16 Intake section evidenced the nurse documented 350 cc flushes at 11:30 AM and 12:50 PM, and a 300 cc flush at 2:05 PM. I. The Nursing Flow Sheet dated 3/15/16 Intake section evidenced the nurse documented 350 cc flushes at 11:00 AM and 12:30 PM, and a 300 cc flush at 2:00 PM. J. The Nursing Flow Sheet dated 3/18/16 Intake section evidenced the nurse documented 300 cc flush at 2:40 PM. K. The Nursing Flow Sheet dated 3/19/16 Intake section evidenced the nurse documented 350 cc flushes at 11:40 AM and 12:30 PM. L. The Nursing Flow Sheet dated 3/20/16 Intake section evidenced the nurse documented 350 cc flushes at 11:00 AM and 12:30 PM. M. The Nursing Flow Sheet dated 3/21/16 Intake section evidenced the nurse documented 400 cc flush at 11:10			

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	AM, and 350 cc flush at 12:30 PM. N. The Nursing Flow Sheet dated 3/22/16 Intake section evidenced the nurse documented 400 cc flush at 11:10 AM, and 350 cc flush at 12:30 PM. O. The Nursing Flow Sheet dated 3/23/16 Intake section evidenced the nurse documented 400 cc flush at 11:15 AM, and 350 cc flush at 12:45 PM. P. The Nursing Flow Sheet dated 3/25/16 Intake section evidenced the nurse documented 350 cc flush at 11:00 AM and 12:45 PM. Q. The Nursing Flow Sheet dated 3/27/16 Intake section evidenced the nurse documented 350 cc flush at 11:10 AM and 12:30 PM. R. The Nursing Flow Sheet dated 3/28/16 Intake section evidenced the nurse documented 350 cc flush at 11:00 AM and 12:35 PM. S. The Nursing Flow Sheet dated 3/29/16 Intake section evidenced the nurse documented 350 cc flush at 11:10 AM and 12:45 PM. T. The Nursing Flow Sheet dated 3/30/16 Intake section evidenced the			

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	nurse documented 350 cc flush at 11:00 AM and 12:30 PM. U. The Nursing Flow Sheet dated 4/2/16 Intake section evidenced the nurse documented 350 cc flush at 11:35 AM and 12:50 PM. 2. The agency's job description titled "Registered Nurse," stated "Performance Standards: ... 6. ... Administers medications and treatment as prescribed by the physician." 3. The agency's job description titled "Licensed Vocational Nurse/Licensed Practical Nurse," stated "Performance Standards: 1. Each shift or visit reflects the provision of skilled nursing care rendered in accordance with physician's orders. ... 2. ... b. Performs specific treatments and medication administration in accordance with physician orders."			

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G 0170 Bldg. 00	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on document review and interview, the agency failed to ensure staff followed the plan of care for 1 of 10 records reviewed. (# 1) Findings include 1. The record for patient #1 was reviewed on 4/14/16. The Plan of Care dated 3/29-5/27/16 contained orders for Home Health Aide (HHA) 5-7 days a week, 17-28 hours per week for 60 days, and skilled nursing (SN) every other day for bowel program and monthly suprapubic catheter change for 60 days, SN orders: observation and assessment every shift for signs of distress including Vital Signs (temperature, pulse, respirations, and blood pressure), assess pain. A. The record failed to evidence the suprapubic catheter had been changed since 2/21/16. B. During interview on 4/15/16 at	G 0170	Skilled Nursing Direct Caregivers for Patient #1 will bere-educated on following physician's orders, to include suprapubic catheterchange, assessing vital signs and assessing pain as ordered on the plan ofcare. 100% review of documentation forpatient # 1 will be performed for 30 days to ensure that all orders for treatment,including suprapubic catheter change, vital signs and pain assessment, arefollowed and documented by the nurses providing care. All skilled nursing staff was assigned Annual ComplianceTraining which includes the importance of documentation and the plan of care,on 5/2/16. Ongoing Nursing flowsheets for 25% of the patient censuswill be reviewed weekly by the Clinical Supervisors as a part of focuseddocumentation review to ensure that direct care staff are following physicianorders. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that direct caregivers, including LPNs	05/19/2016

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	9:00 AM, employee F (Clinical Supervisor) stated the patient said the next catheter change is due this Sunday and the last was on 3/20/16. C. The Skilled Nursing Note dated 3/20/16 failed to evidence the suprapubic catheter had been changed. D. The record failed to evidence the nurses followed the plan of care and checked vital signs every shift. The SN Notes dated 2/21, 3/20, 3/26, 3/28, 3/30, 4/1, 4/7, and 4/9/16 failed to evidence the vital signs were assessed; the nurses had documented "N/A [not applicable]." E. The record failed to evidence the nurses followed the plan of care and assessed pain every shift. The SN Notes dated 2/21, 3/20, 3/26, 4/7, and 4/9/16 failed to evidence pain was assessed; the nurses had documented "N/A [not applicable]." 2. The agency's job description titled "Registered Nurse," stated "Performance Standards: ... 6. ... Administers medications and treatment as prescribed by the physician." 3. The agency's job description titled "Licensed Vocational Nurse/Licensed Practical Nurse," stated "Performance		and RNs, arefollowing the physician orders. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur.	

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	Standards: 1. Each shift or visit reflects the provision of skilled nursing care rendered in accordance with physician's orders. ... 2. ... b. Performs specific treatments and medication administration in accordance with physician orders."			
G 0176 Bldg. 00	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 record review and interview, the agency failed to ensure the nurse documented accurately for 1 of 10 records reviewed, failed to ensure the nurse documented a change in condition for 3 of 10 clinical records reviewed. (#1, 4, 5) Findings include 1. The clinical record for patient # 5 was reviewed on 3/18/16. Start of care date was 3/10/16. The record contained a plan of care dated 3/10-5/8/16 with diagnosis of Chronic Respiratory failure with hypoxia, Dependence on respirator (ventilator), and Encounter for attention to tracheostomy and gastrostomy. The	G 0176	The Clinical Manager will re-educate all ClinicalSupervisors, including Employee E, on company policy "Patient/ClientRecord: Content and Requirements"#MD-CL-002.5 as well as the requirement to conduct and document a complete andthorough Comprehensive Assessment and OASIS. The DOCS/AM/Designee will provide this education with attendanceacknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. Ongoing the Clinical Manager/clinical designeewill conduct a review of Comprehensive Assessments and OASIS completed atRecertification to ensure that the assessment was thoroughly and accuratelydocumented. Patient #5 was discharged on 3/21/16.	05/19/2016

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	plan of care contained orders for Skilled Nursing (SN) services 12-20 hours per day, 5-7 days per week for 60 days. General orders for skilled observation and assessment every shift and as needed for signs of distress including vital signs (temperature, pulse, respirations, and oxygen levels) ... Respiratory orders including Astral 150 Ventilator to be worn 24 hours/day 7 days a week. A. The Nursing Flow Sheet dated 3/16/16 from 6:45 AM-2:05 PM charting stated "1:15 PM." Nothing was charted at 1:15 PM. The record failed to evidence the patient change in condition and actions taken by the nurse. B. During interview on 3/18/16 at 3:50 PM, the Administrator stated that the legal department told employee B (Licensed Practical Nurse) not to chart the incident until the investigation was complete but the agency did call him in for interview to begin the investigation that same day. C. During interview on 3/18/16 at 4:50 PM, per telephone, employee B stated he did not document the incident from 3/16/16 at 1:15 due to the agency told him not to. 2. The record for patient #1 was		All skilled nursing staff, including Employee B, wasassigned Annual Compliance Training which includes the importance of documentationand the plan of care, on 5/2/16. An office process will be developed, based on thePatient/Client Record: Content and Requirements policy, to ensure that allclinical documentation completed by the direct caregivers, to include seizuredocumentation, is turned in to the office weekly. This process will include a tracking systemmanaged by the Field Support Team which includes a 100% of clinicaldocumentation that is turned in weekly by direct caregivers to ensure that allclinical documentation has been submitted to the office. The Field Support Team and ClinicalSupervisors will be educated on the new process, including existing Company Policytitled “Patient/Client Record: Content and Requirements” #MD-CL-002.5. TheClinical Manager/Field Support Manager/Designee will provide this educationwith attendance acknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. All seizure records for Patient #4 are filed in thepatient’s Medical Record. DirectCaregivers for Patient #4 will be re-educated on the requirement to turn in allclinical documentation,	

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	reviewed on 4/14/16. The Plan of Care dated 3/29-5/27/16 contained orders for Home Health Aide (HHA) 5-7 days a week, 17-28 hours per week for 60 days, and skilled nursing (SN) every other day for bowel program and monthly suprapubic catheter change for 60 days, SN orders: observation and assessment every shift for signs of distress including Vital Signs (temperature, pulse, respirations, and blood pressure), assess pain. A. The Outcome Assessment and Information Set (OASIS) document for recertification dated 3/26/16 failed to evidence the information collected reflected the patient status. The section titled "(M1620) Bowel Incontinence Frequency" failed to evidence the patient was on a bowel regimen/program. B. During interview on 4/15/16 at 9:00 AM, employee E (Clinical Supervisor) stated that was a mistake that she failed to mark the patient was on a bowel program. 3. The record for patient # 4 was reviewed on 4/12/16. The start of care for patient # 4 was 10/5/09. The Plan of care dated 3/2-4/30/16 contained orders for skilled nursing SN 4-6 days per week, 26-43 hours per week for 60 days. SN		including seizure records, weekly. To ensure this alleged deficiency does not recur, 10 clinicalrecords or 10% of all clinical records, whichever is greater, will be auditedquarterly to ensure that all clinical documentation has been turned in to theoffice and filed in the Medical Record. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur.	

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	157591	A. BUILDING 00 B. WING	04/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAXIM HEALTHCARE SERVICES INC	4646 W JEFFERSON BLVD STE 100 FORT WAYNE, IN 46804

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	orders included flush g-tube with up to 250 mL [milliliters] of water as needed, before and after medications and as needed per clogged tube. The record failed to evidence seizures had been documented by the nurse. A. The Supervisory Visit Note dated 3/30/16 stated "mild seizure this morning. 2 seizures last week." B. The Nursing Flow Sheet dated 3/30/16 failed to evidence the nurse documented a seizure. C. During interview on 4/12/16 at 11:45 AM, employee J (Alternate Nursing Supervisor) stated the nurses document seizures on the seizure record in the homes. D. During home visit observation on 4/13/16 at 9:30 AM, the seizure documentation was found in the patient home record, but had not been turned in to the agency. During interview at 9:30 AM, employee J stated these are to be turned in with weekly documentation. 4. The agency's policy titled "Patient/Client Record: Content and Requirements," # MD-CL-002.5, dated 10/5/15 stated "3.2. A patient/client record will be maintained for each			

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	patient/client receiving care. The patient/client record will contain sufficient information to: ... 3.2.3. Accurately document care provided and outcome(s) ... 3.3. All documentation shall be completed as care is provided no later than the end of the shift/visit. 3.4. All documentation will be submitted to the office within seven (7) days of the last shift/visit noted on the form. ... 3.4.2. Documentation will be filed in the patient/client record within 14 days of the shift/visit (last shift/visit if a multiple dated form) and/or assessment. ... 4. Documentation Guidelines: ... 4.4. Entries shall include the date (month/date/year) and the time (HH:MM) the care/service was provided." The agency failed to follow this policy. 5. The agency's job description titled "Registered Nurse," stated "Performance Standards: ... 6. ... Administers medications and treatment as prescribed by the physician." 6. The agency's job description titled "Licensed Vocational Nurse/Licensed Practical Nurse," stated "Performance Standards: 1. Each shift or visit reflects the provision of skilled nursing care rendered in accordance with physician's orders. ... 2. ... b. Performs specific treatments and medication administration			

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	in accordance with physician orders."			
G 0225 Bldg. 00	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 document review and interview, the agency failed to ensure the home health aide (HHA) followed the plan of care for 1 of 4 records reviewed of patients receiving HHA services. (# 2) Findings include 1. The record for patient # 2 was reviewed on 4/5/16. The start of care date was 12/18/15. The Plan of Care dated 2/15-4/14/16 contained orders for HHA 3-5 days per week, 6-10 hours per week for 60 days. HHA to check blood pressure and pulse daily and notify Clinical Supervisor if outside parameters-blood pressure to be no greater than 150/100 and not less than 100/60, Pulse to be no greater than 130 and no less than 70. The clinical record failed to evidence the HHA followed the plan of care as ordered.	G 0225	Patient #2 was discharged on 4/14/2016. Employee R was re-educated by Clinical Manager on 5/11/2016regarding proper completion of documentation and following the plan of care. All home health aides, including Employee R, were enrolledin annual compliance training which includes documentation and following thecare plan, on 5/2/16. Ongoing Home Health Aide weekly notes for 25% of the patientcensus will be reviewed weekly by the Clinical Supervisors as a part of focuseddocumentation review to ensure that direct care staff are following the plan ofcare. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that direct caregivers, including home healthaides, are following the plan	05/19/2016

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	A. The Aide Weekly Note dated 3/28/16 by employee R, failed to evidence the HHA checked the patient's blood pressure. 2. The agency's policy titled "Patient/Client Record: Content and Requirements," # MD-CL-002.5, dated 10/5/15, stated "3.2. A patient/client record will be maintained for each patient/client receiving care. The patient/client record will contain sufficient information to: 3.2.3. Accurately document care provided and outcome(s)."		of care. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur.	
G 0235 Bldg. 00	484.48 CLINICAL RECORDS Based on record review and interview, the agency failed to ensure all documentation was complete, accurate, and in the patient record for 4 of 10 clinical records reviewed (See G 236). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.48 Clinical Records.	G 0235	See Response for: G236	05/19/2016

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G 0236 Bldg. 00	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. Based on record review and interview, the agency failed to ensure all documentation was complete, accurate, and in the patient record for 4 of 10 clinical records reviewed. (# 1, 2, 4, 5) Findings include 1. The clinical record for patient # 5 was reviewed on 3/18/16. Start of care date was 3/10/16. The record contained a plan of care dated 3/10-5/8/16 with diagnosis of Chronic Respiratory failure with hypoxia, Dependence on respirator (ventilator), and Encounter for attention to tracheostomy and gastrostomy. The plan of care contained orders for Skilled Nursing (SN) services 12-20 hours per day, 5-7 days per week for 60 days. General orders for skilled observation and assessment every shift and as needed	G 0236	Patient #2 was discharged on 4/14/2016. Clinical Employee R was re-educated by Clinical Manager on 5/11/2016regarding proper completion of documentation and following the plan of care, toinclude obtaining blood pressure when ordered. Patient #5 was discharged on 3/21/16. All skilled nursing staff, including Employee B, wasassigned Annual Compliance Training which includes the importance ofdocumentation and the plan of care, on 5/2/16. The Clinical Manager will re-educate all ClinicalSupervisors, including Employee E, on company policy "Patient/ClientRecord: Content and Requirements"#MD-CL-002.5 as well as the requirement to conduct and document a complete andthorough Comprehensive Assessment and	05/19/2016

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	for signs of distress including vital signs (temperature, pulse, respirations, and oxygen levels) ... Respiratory orders including Astral 150 Ventilator to be worn 24 hours/day 7 days a week. A. The Nursing Flow Sheet dated 3/16/16 from 6:45 AM-2:05 PM charting stated "1:15 PM." Nothing was charted at 1:15 PM. The record failed to evidence the patient change in condition and actions taken by the nurse. B. During interview on 3/18/16 at 3:50 PM, the Administrator stated that the legal department told employee B (Licensed Practical Nurse) not to chart the incident until the investigation was complete but the agency did call him in for interview to begin the investigation that same day. C. During interview on 3/18/16 at 4:50 PM, per telephone, employee B stated he did not document the incident from 3/16/16 at 1:15 due to the agency told him not to. 2. The record for patient #1 was reviewed on 4/14/16. The Plan of Care dated 3/29-5/27/16 contained orders for Home Health Aide (HHA) 5-7 days a week, 17-28 hours per week for 60 days, and skilled nursing (SN) every other day		OASIS. The DOCS/AM/Designee will provide this education with attendanceacknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. Ongoing the Clinical Manager/clinicaldesignee will conduct a review of Comprehensive Assessments and OASIS completedat Recertification to ensure that the assessment was thoroughly and accuratelydocumented. Skilled Nursing Direct Caregivers for Patient #1 will bere-educated on following physician's orders, to include suprapubic catheterchange, assessing vital signs and assessing pain as ordered on the plan ofcare. 100% review of documentation forpatient # 1 will be performed for 30 days to ensure that all orders fortreatment, including suprapubic catheter change, vital signs and painassessment, are followed and documented by the nurses providing care An office process will be developed, based on thePatient/Client Record: Content and Requirements policy, to ensure that allclinical documentation completed by the direct caregivers, to include seizuredocumentation, is turned in to the office weekly. This process will include a tracking systemmanaged by the Field Support Team which includes a 100% of clinicaldocumentation that is turned in weekly by direct	

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	for bowel program and monthly suprapubic catheter change for 60 days, SN orders: observation and assessment every shift for signs of distress including Vital Signs (temperature, pulse, respirations, and blood pressure), assess pain. A. The Outcome Assessment and Information Set (OASIS) document for recertification dated 3/26/16 failed to evidence the information collected reflected the patient status. The section titled "(M1620) Bowel Incontinence Frequency" failed to evidence the patient was on a bowel regimen/program. B. During interview on 4/15/16 at 9:00 AM, employee E (Clinical Supervisor) stated that was a mistake that she failed to mark the patient was on a bowel program. C. The record failed to evidence the suprapubic catheter had been changed since 2/21/16. D. During interview on 4/15/16 at 9:00 AM, employee F (Clinical Supervisor) stated the patient said the next catheter change is due this Sunday and the last was on 3/20/16. E. The Skilled Nursing Note dated		caregivers to ensure that allclinical documentation has been submitted to the office. The Field Support Team and ClinicalSupervisors will be educated on the new process, including existing Company Policytitled “Patient/Client Record: Content and Requirements” #MD-CL-002.5. TheClinical Manager/Field Support Manager/Designee will provide this educationwith attendance acknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. All seizure records for Patient #4 are filed in thepatient’s Medical Record. DirectCaregivers for Patient #4 will be re-educated on the requirement to turn in allclinical documentation, including seizure records, weekly. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that all documentation is complete, accurate and inthe medical record. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur.	

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	3/20/16 failed to evidence the suprapubic catheter had been changed. F. The record failed to evidence the nurses followed the plan of care and checked vital signs every shift. The SN Notes dated 2/21, 3/20, 3/26, 3/28, 3/30, 4/1, 4/7, and 4/9/16 failed to evidence the vital signs were assessed; the nurses had documented "N/A [not applicable]." G. The record failed to evidence the nurses followed the plan of care and assessed pain every shift. The SN Notes dated 2/21, 3/20, 3/26, 4/7, and 4/9/16 failed to evidence pain was assessed; the nurses had documented "N/A [not applicable]." 3. The record for patient # 4 was reviewed on 4/12/16. The start of care for patient # 4 was 10/5/09. The Plan of care dated 3/2-4/30/16 contained orders for skilled nursing SN 4-6 days per week, 26-43 hours per week for 60 days. SN orders included flush g-tube with up to 250 mL [milliliters] of water as needed, before and after medications and as needed per clogged tube. The record failed to evidence seizures had been documented by the nurse. A. The Supervisory Visit Note dated 3/30/16 stated "mild seizure this			

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	morning. 2 seizures last week." B. The Nursing Flow Sheet dated 3/30/16 failed to evidence the nurse documented a seizure. C. During interview on 4/12/16 at 11:45 AM, employee J (Alternate Nursing Supervisor) stated the nurses document seizures on the seizure record in the homes. D. During home visit observation on 4/13/16 at 9:30 AM, the seizure documentation was found in the patient home record, but had not been turned in to the agency. During interview at 9:30 AM, employee J stated these are to be turned in with weekly documentation. 4. The record for patient # 2 was reviewed on 4/5/16. The start of care date was 12/18/15. The Plan of Care dated 2/15-4/14/16 contained orders for HHA 3-5 days per week, 6-10 hours per week for 60 days. HHA to check blood pressure and pulse daily and notify Clinical Supervisor if outside parameters-blood pressure to be no greater than 150/100 and not less than 100/60, Pulse to be no greater than 130 and no less than 70. The clinical record failed to evidence the HHA followed the plan of care as ordered and documented vital signs.			

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A. The Aide Weekly Note dated 3/28/16 by employee R, failed to evidence the HHA checked the patient's blood pressure.

5. The agency's policy titled "Patient/Client Record: Content and Requirements," # MD-CL-002.5, dated 10/5/15 stated "3.2. A patient/client record will be maintained for each patient/client receiving care. The patient/client record will contain sufficient information to: ... 3.2.3. Accurately document care provided and outcome(s) ... 3.3. All documentation shall be completed as care is provided no later than the end of the shift/visit. 3.4. All documentation will be submitted to the office within seven (7) days of the last shift/visit noted on the form. ... 3.4.2. Documentation will be filed in the patient/client record within 14 days of the shift/visit (last shift/visit if a multiple dated form) and/or assessment. ... 4. Documentation Guidelines: ... 4.4. Entries shall include the date (month/date/year) and the time (HH:MM) the care/service was provided."

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N 0000 Bldg. 00	This was a state home health complaint investigation. Complaint #: IN00193591- Substantiated: Deficiencies related to the allegation are cited. IN00163848- Unsubstantiated. Unrelated deficiencies are cited. IN00195924- Unsubstantiated. Unrelated deficiencies are cited. Survey Date: March 18 & 21, April 5 & 11, 12, 13, 14, 15, 18 and 19, 2016 Facility #: IN003757 Medicaid #: 200484160	N 0000	By submitting this POC the agency does not admit theallegations in the survey report or that it violated any regulations. The agency is submitting this POC in responseto its regulatory obligations and commitment to compliance. The agency further reserves the right tocontrast any alleged findings, conclusions and deficiencies. The agency intends to request that this POCservice as its Credible Allegation of Compliance.	
N 0444 Bldg. 00	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the			

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	supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. Based on document review and interview, the agency failed to ensure the administrator was allowed to run the day-to-day operations for 1 of 1 agency. Findings include 1. The record for patient # 2 was reviewed on 4/5/16. The start of care date was 12/18/15. The record contained a plan of care dated 12/17/15-2/14/16 with orders for HHA 3-5 days per week, 7 to 10 hours per week, for 60 days, plus 18 hours a month Attendant care, and 15 hours per month of Homemaker via waiver. The record failed to evidence the agency provided HHA services from 2/5/16 through 3/29/16 due to lack of available staff, and failed to evidence the agency discharged the patient when it was unable to find staff from 2/5-3/29/15. A. During interview on 4/5/16 at 2:00 PM, the Alternate Administrator stated the agency provided HHA services last week for patient #2, but this was the first time since 2/4 when employee K was pulled from the case. The Alternate Administrator stated this patient is currently receiving physical therapy	N 0444	Governing Body members, which includes the Administrator,will meet to review the Administrator's Job description to include theAdministrator's responsibility for organizing and directing the agency'songoing functions. This meeting will bedocumented and meeting minutes maintained in the Governing Body Binder. Ongoing the Governing Body will ensure thatthe Administrator, who is also the Clinical Manager, runs the day to dayoperations of the agency. To ensure this alleged deficiency does not recur, theGoverning Body will meet annually, at minimum, to review the Administrator'sJob Description as well as ensure adherence to overall responsibilities. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur.	05/19/2016

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	services as of 4/4/16, through Lutheran which is another Medicare provider, so HHA services here through Medicaid are on hold. B. During interview on 4/5/16 at 2:00 PM, the Administrative Officer stated for waiver patients, a 30 day discharge notice is required. C. During interview on 4/18/16 at 9:15 AM, the Administrator stated she tried to get patient # 2 discharged due to not having staff available to provide care, but the advisory services of Maxim said not to discharge yet, attempt to find staff. The Administrator stated this patient is being moved to personal care only services, as the patient ended up telling them things that were not true, and the patient can do more for self than the agency was lead to believe, and the patient stated their significant other is able to help the patient. The Administrator stated Maxim has processes in place that have to be followed first, and that she cannot just do what needs to be done without checking first. The Administrator stated discharge is a last resort if we cannot find staff in to service a client. The Administrator stated patient #2 had said a company in New Haven was able to provide services in March, but the patient said no, as the			

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MAXIM HEALTHCARE SERVICES INC	4646 W JEFFERSON BLVD STE 100 FORT WAYNE, IN 46804

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	patient requested to stay with Maxim. 2. The agency's job description titled "Administrator," dated 10/18/2012 stated "The Administrator is appointed by the Governing Body to assume responsibility and accountability for maintaining and directing the ongoing functions of the Home Health Agency. The Administrator is responsible for the overall management of the business affairs of the agency and ensures initial and ongoing compliance with all applicable Federal, State, and local regulations, Company policies and procedures. ... Essential Duties and Responsibilities: ... 2. Adheres to company Policies and Procedures ... 14. Collaborates with office management to ensure compliant management of patient care from referral through discharge ... Compliance & Ethics Expectations: Participates and successfully completes the Company's compliance program requirements and adheres to ... applicable federal and state requirements."			
N 0466 Bldg. 00	410 IAC 17-12-1(j) Home health agency administration/management Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and			

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	(2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). Based on document review and interview, the agency failed to keep employee health information confidential and separate from other didactic information for 9 of 9 employee files reviewed. (B, G, H, I, J, K, L, M, and N) Findings include 1. Employee file B, Licensed Practical Nurse (LPN) was reviewed on 3/21/16. The PF2 [personnel file 2] contained the health information and also evidenced the employee's back ground check information. The agency failed to keep the health information separate and confidential. 2. Employee file G, Home Health Aide (HHA) was reviewed on 4/18/16. The PF2 contained the health information and also evidenced the employee's Criminal Back ground check, W-4 form, payroll #, employee status forms, driver's license verification form, copy of social security card, and Maxim Global Employee Search. The agency failed to keep the health information separate and confidential.	N 0466	All internal field support staff will be educated on IndianaState Regulation 410 IAC 17-12-1(j) – Separate Medical Files as well as companypolicy titled "Personnel Format" #MD-HR-010.5 section 4.2.1. Clinical Manager/AM/Designee will providethis education with attendance acknowledgment and respective documents to bekept in the QI Binder. As of 5/13/16 a 100% review of personnel files, includingEmployees B, G, H, I, J, K, L, M and N, was conducted to ensure that all Employeehealth information is maintained in a confidential file separate from all otherdidactic personnel information. Allpersonnel files have been updated per this requirement and all employee healthinformation is in a separate confidential file. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all personnel files, whichever is greater, will beaudited quarterly to ensure that all employee health information is maintainedin a separate confidential file. The Field Support Manager is responsible for monitoringthese corrective actions to ensure that this alleged deficiency is correctedand	05/19/2016

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	3. Employee file H, LPN, was reviewed on 4/18/16. The PF2 contained the health information and also evidenced the employee's Criminal Back Ground check, Maxim Employee Global Search, W-4 form, driver's license verification form, Pre-Screen Notice and Certification for the Work Opportunity Credit, Payroll generator #, Auto policy declarations, and client transportation forms. The agency failed to keep the health information separate and confidential. 4. Employee file I, LPN, was reviewed on 4/18/16. The PF2 contained the health information and also evidenced the employee's Criminal back ground check, W-4 form, payroll generator #, employee status forms, and driver's license verification form. The agency failed to keep the health information separate and confidential. 5. Employee file J, Registered Nurse (RN), was reviewed on 4/18/16. The PF2 contained the health information and also evidenced the employee's criminal back ground check, driver's license verification form, employee status forms, Pre-Screen Notice and Certification for the Work Opportunity Credit, Maxim Global employee search, and Voluntary self-disclosure forms. The agency failed to keep the health information separate		does not recur.	

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	and confidential. 6. Employee file K, HHA, was reviewed on 4/18/16. The PF2 contained the health information and also evidenced the employee's criminal back ground check, Maxim Global employee search form, voluntary self-disclosure forms, W-4 form, employee status change forms, driver's license verification forms, client transportation authorization form, and driving history form. The agency failed to keep the health information separate and confidential. 7. Employee file L, RN, was reviewed on 4/18/16. The PF2 contained the health information and also evidenced the employee's criminal back ground check, Maxim Global employee search, voluntary disclosure forms, W-4 form, payroll generator #, employee status change forms, and driver's license verification form. The agency failed to keep the health information separate and confidential. 8. Employee file M, HHA, was reviewed on 4/18/16. The PF2 contained the health information and also evidence the employee's criminal back ground check, Maxim global employee search, voluntary self-disclosure forms, W-4 form, employee status change forms, and			

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	driver's license verification form. The agency failed to keep the health information separate and confidential. 9. Employee file N, HHA, was reviewed on 4/18/16. The PF2 contained the health information and also evidenced the employee's criminal back ground checks, Maxim global employee search, voluntary self-disclosure form, W-4 form, employee status form, payroll assigned #, and driver's license verification. The agency failed to keep the health information separate and confidential. 10. During interview on 4/18/16 at 11:40 AM, employee O (Field Support Manager, Human Resources) stated the PF2 list includes the health information with other information that is to be kept confidential, the agency used to keep it separated but there were employee changes last year. 11. The agency's policy titled "Personnel Format," # MD-HR-010.5, dated 9/1/14 stated "4.2. Personnel files are considered to be confidential files. 4.2.1. All health related information on personnel will be maintained in a separate file to maintain confidentiality according to the Americans with Disabilities Act."			

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N 0470 Bldg. 00	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, document review, and interview, the agency failed to ensure staff followed infection control policies and procedures for 1 of 5 home visit observations (patient # 1), failed to adequately meet the needs of 1 patient for 54 days due to lack of available staffing and failed to discharge the patient per policy. (#2) Findings include 1. During home visit observation for patient # 1 on 4/13/16 at 11:30 AM, employee G (HHA) was observed assisting patient with shower. Employee G failed to wash her hands longer than 10 seconds prior to donning gloves. After assisting with washing the patient's back, employee G doffed gloves, and failed to wash hands longer than 8 seconds. Employee G then proceeded to don new gloves and prepare tape for leg bag, when she doffed the gloves, she failed to wash hands for longer than 5 seconds. Prior to donning new gloves, employee G failed to wash hands for longer than 4 seconds,	N 0470	All directcare staff, including Employee G, were sent an in-service mailer on 5/6/16regarding proper handwashing procedure to include hand hygiene. Additionally all direct care staff, includingEmployee G, were provided with a Hand Washing flyer which includes guidelinesfor proper hand washing and hand hygiene on 5/6/16. Employee G was re-assessed on proper handwashing competency on 5/11/16. OngoingClinical Supervisors will observe proper handwashing by direct caregiversduring patient Supervisory Visits when staff are present and document thisobservation on the Supervisory Visit note. Ongoing direct caregivers, including Employee G, will have competency assessedon Infection Control, to include handwashing, annually during office annualskills fair. Patient #2 was discharged on 4/14/16. An office process will be developed, based on the currentMissed Shift Policy, in order to ensure that all missed shifts are documentedand supportive loggings will be entered. All internal office staff will	05/27/2016

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	and after doffing the gloves she failed to wash hands for longer than 5 seconds. 2. During interview on 4/13/16 at 1:15 PM, employee J (Alternate Nurse Supervisor) stated employees are to wash hands for approximately 30 seconds, but may use hand sanitizer if the hands are not soiled, such as in between glove changes. 3. During interview on 4/18/16 at 11:00 AM, the Administrator stated the agency just did skills fair recently and all employees did perform hand washing. 4. The record for patient # 2 was reviewed on 4/5/16. The start of care date was 12/18/15. The record contained a plan of care dated 12/17/15-2/14/16 with orders for HHA 3-5 days per week, 7 to 10 hours per week, for 60 days, plus 18 hours a month Attendant care, and 15 hours per month of Homemaker via waiver. The record failed to evidence the agency provided HHA services from 2/5/16 through 3/29/16 due to lack of available staff, and failed to evidence the agency discharged the patient when it was unable to find staff from 2/5-3/27/15. A. During interview on 4/5/16 at 2:00 PM, the Alternate Administrator stated the agency provided HHA services last		be educated on the new process, includingexisting Missed Shifts Policy. The DOCS/AM/Designee will provide this educationwith attendance acknowledgment and respective documents to be kept in the QIBinder. To be completed by5/17/2016. In order to minimize the future recurrence of missed shifts,the Administrator/Clinical Manager and Accounts Manager/designee will implementand monitor a Recruitment Plan. All internal staff will be educated on thisplan by Accounts Manager/designee with attendance acknowledgement andrespective documents to be kept in the QI binder. **Recruitment Plan:** Our recruitment plan includes a multi-faceted approach directed byAgency Recruiters. This approach includesjob postings to identify new candidates, previous candidate follow-up viaexisting database, referrals through a renewed emphasis on employee engagement,local community events, and resume database searches. Ongoing monitoring by Clinical Manager/Administratorand AM during weekly office meetings will allow for additional activities andexpansion of current activities where deemed necessary. Office will maintain anactive caregiver Float Pool effective 5/27/16. Office will contract with Maxim Staffing Solutions for potentialutilization of	

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	week for patient #2, but this was the first time since 2/4 when employee K was pulled from the case. The Alternate Administrator stated this patient is currently receiving physical therapy services as of 4/4/16, through Lutheran which is another Medicare provider, so HHA services here through Medicaid are on hold. B. During interview on 4/5/16 at 2:00 PM, the Administrative Officer stated for waiver patients, a 30 day discharge notice is required. C. During interview on 4/11/16 at 10:45 AM, the Alternate Administrator stated the agency had been providing wellness checks such as supervisory visits/comprehensive assessments/and recertification visits for the patient since they have been unable to staff a HHA since 2/4/16 until the end of March. The Alternate Administrator stated the agency has also not been able to have any nurses replace and cover HHA shifts due to lack of nurses availability. The Alternate Administrator stated the agency wrote an order to place HHA services on hold as of 3/31/16. The Alternate Administrator stated the patient's significant other has been providing care for the patient before work, at lunch, and after work. The Alternate Administrator stated that		contractual caregiver pool by 5/27/16. **Phase one**: Agency will complete a 100% self-assessmentof the current patient census to determine if patient's needs are being met.This review was completed on 4/21/16 and 5/26/16 and will continue on a monthlybasis during the office monthly Quality Improvement Committee meeting. Ifproblematic areas are identified the Clinical Manager/Administrator/AM willinitiate our multi-faceted approach to narrow down our pool of candidates tothose who possess the skills, meet the availability required to provide ongoingcoverage and are strategically identified based on geographical location fromthe patient's home. **Phase two** of the plan is ongoing activity related torecruitment of caregivers. This ongoing plan is managed by expectationsof frequency related to activity. Agency Recruiters are responsible forrecruiting float pool caregivers, creating new job postings, following up withexisting candidates, engaging with current employees to offer additional workopportunities to those who desire more hours, participate in local communityhealth related job fairs, contacting contracted staffing agencies and sourcecurrent resumes in our resume database. AM and/or designee carefully monitoractivity	

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	Maxim has been attempting recruiting efforts since 2/4/16, and that Aging and In-Home Services is looking for another home health agency for the patient. D. During interview on 4/18/16 at 9:15 AM, the Administrator stated she tried to get patient # 2 discharged due to not having staff available to provide care, but the advisory services of Maxim said not to discharge yet, attempt to find staff. The Administrator stated this patient is being moved to personal care only services, as the patient ended up telling them things that were not true, and the patient can do more for self than the agency was lead to believe, and the patient stated their significant other is able to help the patient. The Administrator stated Maxim has processes in place that have to be followed first, and that she cannot just do what needs to be done without checking first. The Administrator stated discharge is a last resort if we cannot find staff in to service a client. The Administrator stated patient #2 had said a company in New Haven was able to provide services in March, but the patient said no, as the patient requested to stay with Maxim. E. The clinical record failed to evidence the agency provided HHA services since 2/4/16.		on a daily, weekly and monthly basis to ensure that activity standardsare met to support personnel needs. In addition to the Recruitment plan the Administrator andAccounts Manager/designee will implement daily meetings including “Red Zone” and“Wednesday Clear” to identify areas of concern and activity surroundingrecruitment and staffing issues as evidenced by weekly meeting minutes. “Red Zone” is a daily meeting that occurs toidentify priorities and action items within the office and to ensure that theassociated team members have plans to address, complete, and follow up within atimely manner. “Wednesday Clear” is aproactive communication and planning process to identify any staffingconcern(s) and/or open visit/ shifts 10 days in advance, and then to developspecific action plan(s) to meet the patient needs, cover any open visit/ shift,and then to communicate with the patient and/or PCG in a timely manner. An office process will be developed, based on the currentDischarge Policy, in order to ensure that patient discharge will be initiatedwhen one or more discharge criteria is met per Company policy, includingongoing failure to substantially meet staffing requirements per physicianorders. In the event that we experience ongoing failure of our efforts tosubstantially meet a patient’s	

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	1. Missed Visit/Shift Notifications were completed for: 2/5, 2/15, and 2/17/16, with reason "Declined Qualified Caregiver;" Client/Facility loggings failed to evidence the agency had found staff to cover these dates. 2. Missed Visit/Shift Notifications were completed for: 2/8, 2/10, 2/11, 2/12, 2/13, 2/22, 2/24, 2/26, 2/29, 3/2, 3/4, 3/7, 3/9, 3/11, 3/14, 3/16, and 3/18/16 with reason "employee availability." Client/Facility loggings failed to evidence the agency had found staff to cover these dates. 3. The Client/Facility logging dated 3/9/16 at 11:25 AM, stated "Informed [nurse from Dr. office] client's recertification ends 4/14/16 and if we are unable to provide staff by then, more than likely we will have to discharge. Informed her of recruiting efforts, and case manager is aware and is attempting to find client a different home care agency that is able to provide staff in the ... area." The record failed to evidence the agency had found staff to cover and failed to evidence the agency planned to discharge before 4/14/16. 4. The Client/Facility logging dated 3/22/16 at 1:45 PM was a note by the		scheduling needs, and available staff cannot beidentified, Agency will commence the discharge process. All internal officestaff will be educated on the new process, including existing Company Policy titled“Discharge” #MD-CL-013.9. The ClinicalManager/Account Manager/Designee will provide this education with attendanceacknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that the agency has adequately met Patient staffingneeds and ensure compliance with Company Discharge Policy. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur. Completion Date: 5/27/16	

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	Administrator, who had made a visit to the patient. This note stated "3/18/16 ... When asked how [patient] was able to shower and get dressed, client stated [patient] gets up at 5 am with [significant other] before [significant other] goes to work and [significant other] helps [patient] shower and get dressed. During the visit, observed client walking to the bathroom. ... Client was able to use the bathroom alone without assistance. When asked how [patient] was able to get [their] meals during the day, client replied that [significant other] comes home on lunch every day to let the dog outside and will ask ... if [patient] needs anything. If [patient] gets hungry before or after [significant other] lunch break, client states [patient] is able to prepare [self] canned soup and heat it up in the microwave. [Patient] also states [patient] is able to make [self] a sandwich." This logging failed to evidence discussion of possible discharge. 5. The Client/Facility logging dated 3/22/16 at 11:15 AM stated "Spoke with client's case manager. She stated she found a home care agency to take over. The company is Acti-Kare and services will begin 4/1/16. There is a possibility client will be discharged tomorrow. ... [Aging and In-Home Case Manager] is still trying to find a PA			

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	approved company that will provide the services. She stated she may have to increase client Attendant care to accommodate for therapy. Clarified we are still unable to staff permanently." The record failed to evidence the agency discharged the patient. 6. An email dated 3/23/16 from employee P to Ft. Wayne HH stated "[Patient] told me on the phone that [they] would like to stay on board with us and not change companies. I told [patient] that we have someone coming in from the [patient town] area but that I couldn't make any promises on whether or not the worker could staff [patient] and that I wouldn't know until after the interview. [Patient] said that [they] didn't care and that [they] wanted to stay on board with us." The record failed to evidence the agency followed its own discharge policy. 5. The agency's policy titled "Discharge," # MD-CL-013.9, dated 1/11/16 stated "5. Discharge Criteria: 5.1. Services will be discontinued when the patient/client meets one (1) or more of the following discharge criteria: ... 5.1.6. Available resources, services, or personnel are inadequate for the continuing needs of the patient/client."			

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N 0498 Bldg. 00	410 IAC 17-12-3(b)(2)(A) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (A) Have his or her property treated with respect. Based on document review and interview, the agency failed to ensure staff treated patient property with respect for 1 of 1 agency. Findings include 1. The record for patient # 2 was reviewed on 4/5/16. The start of care date was 12/18/15. The record contained a plan of care dated 12/17/15-2/14/16 with orders for HHA 3-5 days per week, 7 to 10 hours per week, for 60 days, plus 18 hours a month Attendant care, and 15 hours per month of Homemaker via waiver. A. The Client/Facility Logging Report dated 2/4/16 at 2:00 PM, evidenced employee E (Registered Nurse Clinical Supervisor) had conducted a	N 0498	Patient #2 was discharged on 4/14/2016. Employee K was given verbal correction and re-education on 5/13/2016. Employee N was given verbal correction and re-education on5/11/2016. All internal office staff will be re-educated on CompanyPolicy titled "Patient/Client Rights and Responsibilities" #MD-ERR-001.6 toensure that all internal staff members understand the requirement to ensure Employeestreat Patient's property with respect. TheClinical Manager/Accounts Manager/Designee will provide this education withattendance acknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. A grievance for Patient #2 specifically related to employeeN was opened on 4/12/16 and closed on 4/19/16	05/19/2016

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	157591	A. BUILDING 00 B. WING	04/19/2016

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	visit for patient #2 and noted the client had multiple accusations against the HHA, employee K. Employee E noted the patient complained that the HHA was constantly asking the patient for the Vicodin pills and some came up missing; the patient reported the prescription needed to be refilled and the HHA is constantly asking the patient to refill them; patient claimed they did not give any to the HHA but is reluctant to fill the prescription due to the HHA asking; patient reported the HHA was asking the patient to sign time sheets she did not work and was leaving early; patient claimed HHA left shifts early to buy cigarettes for the HHA's significant other, and while out for doctor appointment the HHA stopped by her house to pick up her significant other; patient claimed the HHA used the patient's credit card to buy herself a sandwich; HHA was not taking the patient's blood pressures as ordered by the physician; HHA was not completing housekeeping duties properly; and HHA was not properly bathing the patient and/or not being in the bathroom while the patient was in the shower. 1. The agency complaint/grievance log failed to evidence these accusations had been documented as of 3/18/16. 2. During interview on 4/5/16 at		after an internal investigationwas completed. An office process will be developed, based on the currentGrievance Policy, in order to ensure that all complaints or concerns regarding treatmentor care that is (or fails to be) furnished, or regarding the lack of respect of patient's property byanyone furnishing services are documented and investigated with resolution. This process will include a weekly review ofthe grievance log by the Clinical Manager and AM/designee to ensure that allcomplaints and concerns have been documented and are being investigated perCompany policy. All internal officestaff will be educated on the new process, including existing Company Policytitled "Grievance and Complaints" #MD-ERR-005.7. The Clinical Manager/AccountsManager/Desi gnee will provide this education with attendance acknowledgment andrespective documents to be kept in the QI Binder. To be completed by 5/19/2016. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, as wellas the Grievance log, will be audited quarterly to ensure that all complaints,including those related to lack of respect of property, are documented andinvestigated per policy. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure	

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	1:55 PM, employee D (Alternate Administrator) stated all active legal issues do not go in the complaint/grievance log due to the nature of the allegations. Employee F (Administrative Officer) stated this was a legal issue versus a grievance so once the investigation is complete then it will be filed in the grievance log. 3. The document titled "Incident Report: Interview Summary" was provided on 4/5/16. This document was dated 2/5/16 and was the interview of HHA employee K, by the Administrator and Alternate Administrator. This document stated "[employee K] stated she had never taken or asked for medication. She stated all medications are kept on top of the fridge in a lock box and [patient] keeps the key close ... at all times. ... [Employee K] stated she would not forge any times and the only time she left early was on 2/4/2016 when [employee K's spouse] broke [employee's] hand. [Patient] signed that time sheet. ... [When asked about leaving to take spouse cigarettes, employee K] stated that was not true. ... [When asked about using patient credit card to buy herself a sandwich, employee K] admitted to this but stated [patient] had given her permission to do so because [employee K] had bout [patient] food		that this alleged deficiency is corrected and doesnot recur.	

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	once before. The AM and DOCS addressed this during the interview. We reeducated [employee K] that she is not to buy food for patients with her money and she is not to accept food from patients. [Patient stated aide not taking blood pressures on a consistent basis, employee K] admitted to this, but reeducation was done in the home when this was reported. [Patient stated employee K did a poor job cleaning the client's home, employee K] stated she does clean the home on a daily basis. We the AM and DOCS did their in-home case conference and the home was very clean. [Patient stated employee K would not help patient shower and bathe, employee K] stated [patient] would go to the bathroom by [self] and not allow [employee K] to provide care during those times. The AM reached out to the other families [employee K] works for and they had nothing but positive things to say about [employee K], not a single other patient had any issues." This interview failed to include investigation of the allegation that the employee stopped by their house to pick up their significant other while out for a physician appointment with the patient. 4. The document titled "Incident Report: Interview Summary" was provided on 4/5/16. This document was			

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	dated 2/8/16 and was the interview of patient # 2, by the Administrator, Alternate Administrator, and employee P (Recruiter/Scheduler). This document stated "We asked [patient #2] to clarify ... allegation of [employee K] asking and taking medications- [patient] stated [employee K] never took anything, but would ask [patient] to schedule an appointment with ... pain specialist because [patient] would let [employee] know [patient/s] pain medication is almost gone. [Patient] stated [employee K] would ask ... on a daily basis if the appointment had been made and [patient] was tired of [employee] asking so [patient] decided [patient] wasn't going to go to the pain specialist. We asked [patient] if [employee K] had access to ... locked medication box, [patient] said no. We asked [patient] to clarify [employee K] leaving early and forging time sheets- [patient] stated [they] really didn't remember [employee K] leaving early and doesn't pay attention to the times when [patient] signs off on time sheets. We asked [patient] to clarify [employee K] leaving to buy [employee's spouse] cigarettes- [patient] stated that [employee K] would buy cigarettes for [employee's spouse] when they would go to Wal-Mart together but not take them to [employee's spouse] at work. We asked [patient] to clarify [employee K] using			

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	[patient's] credit card for a sandwich- [patient] stated that [patient] gave [employee K] ... card and told [employee K] it was ok for [employee K] to buy ... a sandwich since [employee K] had bought [patient] food previously. We made sure to clarify to [patient] ... is not to accept food from our aides and shouldn't let our aides buy their own food with [patient] money. We informed [patient, employee K] had been reeducated by our Clin Sup [employee E] on how to properly take blood pressure. We asked [patient] to clarify ... statement that [employee K] wasn't cleaning properly- [patient] stated that [employee K] does a good job. We asked [patient] if ... allows [employee K] to assist ... in the bathroom and shower. [Patient] stated [patient] does, but sometimes [employee K] does not want to help. (This is contradictory to [employee K's] interview). [Patient] stated ... would not like [employee K] back out to [their] home. We let [patient] know we did not have anyone in the pipeline for this area, but we would recruit. [Patient] stated [they] got in touch with an old aide and [that aide] said [they] had applied with Maxim. We informed [patient] that aide called us and told us [patient] got her fired from her last job and would never work in that home again no matter what company [patient] was with. We called			

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	[patient ' s] case manager to inform her of our case conference and she stated this isn't the first time [patient] had made the allegations against [patient ' s] aides and [patient] is a "home care company jumper"." This interview failed to include investigation of the allegation that the employee stopped by their house to pick up their significant other while out for a physician appointment with the patient. 5. The agency provided a document titled "Specimen Result Certificate" dated 3/3/16 for employee K drug screen. It stated "Specimen Type: Urine. ... Final Result Disposition: Negative." 6. During interview on 4/18/16 at 10:00 AM, the Administrator stated this complaint should have been documented in the complaint log as it is still a grievance, but was sent to the legal department due to the allegations of drugs missing it was recorded as an incident. The Administrator stated they have not had any further complaints about employee K. 7. During interview on 4/18/16 at 10:20 AM, the Administrator stated this investigation is not complete yet because apparently the patient also complained			

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	about another HHA (employee N) not completing tasks. 2. The agency's policy titled "Grievances and Complaints," # MD-ERR-005.7, date 1/11/16 stated, "4. Definitions: 4.1. Grievance: Any report (written or verbal) of dissatisfaction or concern with the care and or service delivery that does not result in actual or potential harm or danger to the patient/client and/or family/caregiver. A grievance is considered synonymous with complaint. ... 5.3. Grievances received from a patient/client and/or family/caregiver will be documented on a Patient Grievance form. ... 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 resolution and ensure satisfaction. ... 5.3.2.4. The investigation shall be completed within 30 days or sooner if required by law. ... 5.4. The DOCS, clinical designee or AM shall enter the grievance in the system of record. A recording of all investigative activities, outcomes and analyses shall be included in the report. 5.4.1. The documentation shall be maintained in the Grievance Binder."			

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	3. The agency's policy titled "Patient/Client Rights and Responsibilities," # MD-ERR-001.6, dated 10/5/15 stated, "5.2. Home care patients/clients have the right to: 5.2.3. Be admitted for services only if the agency has the ability to provide safe, professional care ... and to provide continuity of care. ... 5.2.13. Have one's property and person treated with respect, consideration, and recognition of patient/client dignity and individuality. ... 5.2.15. Be free from mistreatment, and misappropriation of patient/client property. ... 5.2.16. Voice grievances/complaints regarding treatment or care that is or fails to be furnished, lack of respect of property."			
N 0514 Bldg. 00	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.			

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	(2) Document both the existence of the complaint and the resolution of the complaint. Based on document review and interview, the agency failed to document the existence of 2 patient complaints in the grievance log, failed to ensure all allegations were investigated for 1 complaint, and failed to follow its own policy for 2 complaints. (#2 and 5) Findings include 1. The agency complaint log was reviewed on 3/18/16. The complaint log failed to evidence any complaints about patients with ventilators, trachs, medical emergencies, or lack of care to such patients; and failed to evidence any complaints of missing medications, and any complaints concerning patient #2 and employee K (HHA). 2. The record for patient # 2 was reviewed on 4/5/16. The start of care date was 12/18/15. The record contained a plan of care dated 12/17/15-2/14/16 with orders for HHA 3-5 days per week, 7 to 10 hours per week, for 60 days, plus 18 hours a month Attendant care, and 15 hours per month of Homemaker via waiver. A. The Client/Facility Logging	N 0514	Patient #2 was discharged on 4/14/2016. Patient #5 was discharged on 3/21/16. Employee K was given verbal correction and re-education on5/13/2016. Employee N was given verbal correction and re-education on5/11/2016. All internal office staff will be re-educated on CompanyPolicy titled "Patient/Client Rights and Responsibilities" #MD-ERR-001.6 toensure that all internal staff members understand the requirement to ensureEmployee's treat Patient's property with respect. The Clinical Manager/Accounts Manager/Designeewill provide this education with attendance acknowledgment and respectivedocuments to be kept in the QI Binder. Tobe completed by 5/19/2016. An office process will be developed, based on the current GrievancePolicy, in order to ensure that all complaints or concerns regarding treatmentor care that is (or fails to be) furnished, or regarding the lack of respect of patient's property byanyone furnishing services are documented and investigated with resolution. This process will include a weekly review ofthe grievance log by the	05/19/2016

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	Report dated 2/4/16 at 2:00 PM, evidenced employee E (Registered Nurse Clinical Supervisor) had conducted a visit for patient #2 and noted the client had multiple accusations against the HHA, employee K. Employee E noted the patient complained that the HHA was constantly asking the patient for the Vicodin pills and some came up missing; the patient reported the prescription needed to be refilled and the HHA is constantly asking the patient to refill them; patient claimed they did not give any to the HHA but is reluctant to fill the prescription due to the HHA asking; patient reported the HHA was asking the patient to sign time sheets she did not work and was leaving early; patient claimed HHA left shifts early to buy cigarettes for the HHA's significant other, and while out for doctor appointment the HHA stopped by her house to pick up her significant other; patient claimed the HHA used the patient's credit card to buy herself a sandwich; HHA was not taking the patient's blood pressures as ordered by the physician; HHA was not completing housekeeping duties properly; and HHA was not properly bathing the patient and/or not being in the bathroom while the patient was in the shower. 1. The agency complaint/grievance log failed to evidence these accusations		Clinical Manager and AM/designee to ensure that allcomplaints and concerns have been documented and are being investigated perCompany policy. All internal office staff will be educated onthe new process, including existing Company Policy titled "Grievance andComplaints" #MD-ERR-005.7. The Clinical Manager/Accounts Manager/Designee willprovide this education with attendance acknowledgment and respective documentsto be kept in the QI Binder. To becompleted by 5/19/2016. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, as wellas the Grievance log, will be audited quarterly to ensure that all complaintsmade by a patient or the patient's family or guardian regarding treatment orcare that is (or fails to be) furnished, or regarding the lack of respect forthe patient's property by anyone furnishing services on behalf of the agency, aredocumented and investigated to resolution per policy. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur.	

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	had been documented as of 3/18/16. 2. During interview on 4/5/16 at 1:55 PM, employee D (Alternate Administrator) stated all active legal issues do not go in the complaint/grievance log due to the nature of the allegations. Employee F (Administrative Officer) stated this was a legal issue versus a grievance so once the investigation is complete then it will be filed in the grievance log. 3. The document titled "Incident Report: Interview Summary" was provided on 4/5/16. This document was dated 2/5/16 and was the interview of HHA employee K, by the Administrator and Alternate Administrator. This document stated "[employee K] stated she had never taken or asked for medication. She stated all medications are kept on top of the fridge in a lock box and [patient] keeps the key close ... at all times. ... [Employee K] stated she would not forge any times and the only time she left early was on 2/4/2016 when [employee K's spouse] broke [employee's] hand. [Patient] signed that time sheet. ... [When asked about leaving to take spouse cigarettes, employee K] stated that was not true. ... [When asked about using patient credit card to buy herself a sandwich, employee K]			

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	admitted to this but stated [patient] had given her permission to do so because [employee K] had bout [patient] food once before. The AM and DOCS addressed this during the interview. We reeducated [employee K] that she is not to buy food for patients with her money and she is not to accept food from patients. [Patient stated aide not taking blood pressures on a consistent basis, employee K] admitted to this, but reeducation was done in the home when this was reported. [Patient stated employee K did a poor job cleaning the client's home, employee K] stated she does clean the home on a daily basis. We the AM and DOCS did their in-home case conference and the home was very clean. [Patient stated employee K would not help patient shower and bathe, employee K] stated [patient] would go to the bathroom by [self] and not allow [employee K] to provide care during those times. The AM reached out to the other families [employee K] works for and they had nothing but positive things to say about [employee K], not a single other patient had any issues." This interview failed to include investigation of the allegation that the employee stopped by their house to pick up their significant other while out for a physician appointment with the patient.			

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	4. The document titled "Incident Report: Interview Summary" was provided on 4/5/16. This document was dated 2/8/16 and was the interview of patient # 2, by the Administrator, Alternate Administrator, and employee P (Recruiter/Scheduler). This document stated "We asked [patient #2] to clarify ... allegation of [employee K] asking and taking medications- [patient] stated [employee K] never took anything, but would ask [patient] to schedule an appointment with ... pain specialist because [patient] would let [employee] know [patient/s] pain medication is almost gone. [Patient] stated [employee K] would ask ... on a daily basis if the appointment had been made and [patient] was tired of [employee] asking so [patient] decided [patient] wasn't going to go to the pain specialist. We asked [patient] if [employee K] had access to ... locked medication box, [patient] said no. We asked [patient] to clarify [employee K] leaving early and forging time sheets- [patient] stated [they] really didn't remember [employee K] leaving early and doesn't pay attention to the times when [patient] signs off on time sheets. We asked [patient] to clarify [employee K] leaving to buy [employee's spouse] cigarettes- [patient] stated that [employee K] would buy cigarettes for [employee's spouse] when they would go			

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	to Wal-Mart together but not take them to [employee's spouse] at work. We asked [patient] to clarify [employee K] using [patient's] credit card for a sandwich- [patient] stated that [patient] gave [employee K] ... card and told [employee K] it was ok for [employee K] to buy ... a sandwich since [employee K] had bought [patient] food previously. We made sure to clarify to [patient] ... is not to accept food from our aides and shouldn't let our aides buy their own food with [patient] money. We informed [patient, employee K] had been reeducated by our Clin Sup [employee E] on how to properly take blood pressure. We asked [patient] to clarify ... statement that [employee K] wasn't cleaning properly- [patient] stated that [employee K] does a good job. We asked [patient] if ... allows [employee K] to assist ... in the bathroom and shower. [Patient] stated [patient] does, but sometimes [employee K] does not want to help. (This is contradictory to [employee K's] interview). [Patient] stated ... would not like [employee K] back out to [their] home. We let [patient] know we did not have anyone in the pipeline for this area, but we would recruit. [Patient] stated [they] got in touch with an old aide and [that aide] said [they] had applied with Maxim. We informed [patient] that aide called us and told us [patient] got her			

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	fired from her last job and would never work in that home again no matter what company [patient] was with. We called [patient ' s] case manager to inform her of our case conference and she stated this isn't the first time [patient] had made the allegations against [patient ' s] aides and [patient] is a "home care company jumper"." This interview failed to include investigation of the allegation that the employee stopped by their house to pick up their significant other while out for a physician appointment with the patient. 5. The agency provided a document titled "Specimen Result Certificate" dated 3/3/16 for employee K drug screen. It stated "Specimen Type: Urine. ... Final Result Disposition: Negative." 6. During interview on 4/18/16 at 10:00 AM, the Administrator stated this complaint should have been documented in the complaint log as it is still a grievance, but was sent to the legal department due to the allegations of drugs missing it was recorded as an incident. The Administrator stated they have not had any further complaints about employee K. 7. During interview on 4/18/16 at			

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	10:20 AM, the Administrator stated this investigation is not complete yet because apparently the patient also complained about another HHA (employee N) not completing tasks. 3. The clinical record for patient # 5 was reviewed on 3/18/16. Start of care date was 3/10/16. The record contained a plan of care dated 3/10-5/8/16 with diagnosis of Chronic Respiratory failure with hypoxia, Dependence on respirator (ventilator), and Encounter for attention to tracheostomy and gastrostomy. The plan of care contained orders for Skilled Nursing (SN) services 12-20 hours per day, 5-7 days per week for 60 days. General orders for skilled observation and assessment every shift and as needed for signs of distress including vital signs (temperature, pulse, respirations, and oxygen levels) ... Respiratory orders including Astral 150 Ventilator to be worn 24 hours/day 7 days a week. A. The Nursing Flow Sheet dated 3/16/16 from 6:45 AM-2:05 PM charting stated "1:15 PM." Nothing was charted at 1:15 PM. The record failed to evidence the patient change in condition and actions taken by the nurse. B. During interview on 3/18/16 at 3:50 PM, the Administrator stated that			

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	the legal department told employee B (Licensed Practical Nurse) not to chart the incident until the investigation was complete but the agency did call him in for interview to begin the investigation that same day. C. During interview on 3/18/16 at 2:30 PM, the Administrator stated the incident that happened with patient #5 is a protected case, meaning she cannot give more than the chart until she contacts Maxim's legal department, but she could provide the incident report but no copies of it. The Administrator stated the incident happened on 3/16/16. 4. The agency's policy titled "Grievances and Complaints," # MD-ERR-005.7, date 1/11/16 stated, "4. Definitions: 4.1. Grievance: Any report (written or verbal) of dissatisfaction or concern with the care and or service delivery that does not result in actual or potential harm or danger to the patient/client and/or family/caregiver. A grievance is considered synonymous with complaint. ... 5.3. Grievances received from a patient/client and/or family/caregiver will be documented on a Patient Grievance form. ... 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			

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	the issue. Once resolution is achieved, the DOCS, clinical designee or AM will contact and inform the person of the resolution and ensure satisfaction. ... 5.3.2.4. The investigation shall be completed within 30 days or sooner if required by law. ... 5.4. The DOCS, clinical designee or AM shall enter the grievance in the system of record. A recording of all investigative activities, outcomes and analyses shall be included in the report. 5.4.1. The documentation shall be maintained in the Grievance Binder." 5. The agency's policy titled "Patient/Client Rights and Responsibilities," # MD-ERR-001.6, dated 10/5/15 stated, "5.2. Home care patients/clients have the right to: 5.2.3. Be admitted for services only if the agency has the ability to provide safe, professional care ... and to provide continuity of care. ... 5.2.13. Have one's property and person treated with respect, consideration, and recognition of patient/client dignity and individuality. ... 5.2.15. Be free from mistreatment, and misappropriation of patient/client property. ... 5.2.16. Voice grievances/complaints regarding treatment or care that is or fails to be furnished, lack of respect of property."			

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N 0520 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. Based on document review and interview, the agency failed to adequately meet the needs of 1 patient for 54 days due to lack of available staffing and failed to discharge the patient per policy. (#2) Findings include 1. The record for patient # 2 was reviewed on 4/5/16. The start of care date was 12/18/15. The record contained a plan of care dated 12/17/15-2/14/16 with orders for HHA 3-5 days per week, 7 to 10 hours per week, for 60 days, plus 18 hours a month Attendant care, and 15 hours per month of Homemaker via waiver. The record failed to evidence the agency provided HHA services from 2/5/16 through 3/29/16 due to lack of available staff, and failed to evidence the agency discharged the patient when it was unable to find staff from 2/5-3/27/15.	N 0520	Patient #2 was discharged on 4/14/16. In order to ensure that patient staffing needs are being metthe Administrator has put measures in place to include routine review ofpatient census through daily “Red Zone” meetings, weekly “Wednesday Clear”program, and monthly Quality Improvement Committee meetings all of which areexplained in the plan below. Additionally, the Administrator will implement the followingaction items: 1. Implementa caregiver “Float Pool” program a. For the express purpose of coveringopen shifts related to staff cancellations, vacations, or other reasons causingopen shifts, excluding client refusal of available, competent staff. b. Ideal candidates will have therequisite level of experience to meet the patient’s care needs/ requirementsand committed	05/27/2016

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	A. During interview on 4/5/16 at 2:00 PM, the Alternate Administrator stated the agency provided HHA services last week for patient #2, but this was the first time since 2/4 when employee K was pulled from the case. The Alternate Administrator stated this patient is currently receiving physical therapy services as of 4/4/16, through Lutheran which is another Medicare provider, so HHA services here through Medicaid are on hold. B. During interview on 4/5/16 at 2:00 PM, the Administrative Officer stated for waiver patients, a 30 day discharge notice is required. C. During interview on 4/11/16 at 10:45 AM, the Alternate Administrator stated the agency had been providing wellness checks such as supervisory visits/comprehensive assessments/and recertification visits for the patient since they have been unable to staff a HHA since 2/4/16 until the end of March. The Alternate Administrator stated the agency has also not been able to have any nurses replace and cover HHA shifts due to lack of nurses availability. The Alternate Administrator stated the agency wrote an order to place HHA services on hold as of 3/31/16. The Alternate Administrator stated the patient's significant other has		availability. 2. Implementcontractual agreements with Maxim Staffing Solutions a. Forthe express purpose of covering open shifts related to staff cancellations,vacations, or other reasons causing open shifts, excluding client refusal ofavailable, competent staff when all other options have been exhausted. The current patient census was reviewed on 4/21/16 and againon 5/26/16 to determine if patient staffing needs are being met. This patient census review will be completed atminimum on a monthly ongoing basis as part of the office Quality ImprovementCommittee meeting. Documentation of thisreview will be maintained in the Quality Improvement Binder. When problematicstaffing areas are identified, the office will adhere to the following process forthose patients who are at risk of needs not being met: ·Recruiters will call all primary and secondarydirect caregivers to check their availability to meet the staffing requirementper the patient's plan of care. If theprimary and secondary caregivers are unavailable, qualified staff will beidentified from current caregiver roster, to include float pool staff andcontracted workers as explained below, and reviewed with the patient andprimary	

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	been providing care for the patient before work, at lunch, and after work. The Alternate Administrator stated that Maxim has been attempting recruiting efforts since 2/4/16, and that Aging and In-Home Services is looking for another home health agency for the patient. D. During interview on 4/18/16 at 9:15 AM, the Administrator stated she tried to get patient # 2 discharged due to not having staff available to provide care, but the advisory services of Maxim said not to discharge yet, attempt to find staff. The Administrator stated this patient is being moved to personal care only services, as the patient ended up telling them things that were not true, and the patient can do more for self than the agency was lead to believe, and the patient stated their significant other is able to help the patient. The Administrator stated Maxim has processes in place that have to be followed first, and that she cannot just do what needs to be done without checking first. The Administrator stated discharge is a last resort if we cannot find staff in to service a client. The Administrator stated patient #2 had said a company in New Haven was able to provide services in March, but the patient said no, as the patient requested to stay with Maxim.		caregiver as an option to meet staffing need; if acceptable, the newstaff will receive a patient specific orientation from the ClinicalSupervisor/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. ·A caregiver float pool program will be developedby 5/27/16 as a tertiary option to fill patient staffing needs. Float pool staff will be available for calloffs and other staffing gaps on an as needed basis. Float pool staff will only be utilized tocover patients for which they are qualified. Float pool staff will receive a patient specific orientation from theClinical Supervisor/clinical designee prior to working the shift. ·Measures have been taken by the Administrator toensure a contractual agreement with Maxim Staffing Solutions to assist withproviding a qualified caregiver in the event an open shift cannot be filled bythe Home Health Agency's own employee pool. If no staff is available, to include primary, secondary, tertiary andfloat pool, the agency will notify contracted agency for staffing options. If no staff available, the patient,	

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	E. The clinical record failed to evidence the agency provided HHA services since 2/4/16. 1. Missed Visit/Shift Notifications were completed for: 2/5, 2/15, and 2/17/16, with reason "Declined Qualified Caregiver;" Client/Facility loggings failed to evidence the agency had found staff to cover these dates. 2. Missed Visit/Shift Notifications were completed for: 2/8, 2/10, 2/11, 2/12, 2/13, 2/22, 2/24, 2/26, 2/29, 3/2, 3/4, 3/7, 3/9, 3/11, 3/14, 3/16, and 3/18/16 with reason "employee availability." Client/Facility loggings failed to evidence the agency had found staff to cover these dates. 3. The Client/Facility logging dated 3/9/16 at 11:25 AM, stated "Informed [nurse from Dr. office] client's recertification ends 4/14/16 and if we are unable to provide staff by then, more than likely we will have to discharge. Informed her of recruiting efforts, and case manager is aware and is attempting to find client a different home care agency that is able to provide staff in the ... area." The record failed to evidence the agency had found staff to cover and failed to evidence the agency planned to discharge before 4/14/16.		primarycaregiver, physician and patient's case manager are notified and alternateforms of care are discussed. Allcommunications will be recorded in the system of record. If it is identified that staffing unavailabilitywill not be intermittent but long term, then there will be increasedrecruitment efforts as identified in the recruitment strategy outlined later inthis response. ·If these increased efforts to staff the patientper the physician ordered frequency are not effective, then we will refer tothe discharge policy as we will have met one of the criteria for discharge thatstates available personnel are not adequate for the continuing needs of theclient. ·Internal Office staff will be educated on thisprocess by 5/27/16. The DOCS/AM/Designeewill provide this education with attendance acknowledgment and respectivedocuments to be kept in the QI Binder. An office intake process has been developed based on companypolicy titled "Acceptance and Admission" MD-CL-006.3 This process includes steps to ensure thatpatients are not accepted into service without the resources available toprovide care. During the intake processthe office referral team will evaluate all new referrals for staffing needs anda schedule of available, qualified	

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	4. The Client/Facility logging dated 3/22/16 at 1:45 PM was a note by the Administrator, who had made a visit to the patient. This note stated "3/18/16 ... When asked how [patient] was able to shower and get dressed, client stated [patient] gets up at 5 am with [significant other] before [significant other] goes to work and [significant other] helps [patient] shower and get dressed. During the visit, observed client walking to the bathroom. ... Client was able to use the bathroom alone without assistance. When asked how [patient] was able to get [their] meals during the day, client replied that [significant other] comes home on lunch every day to let the dog outside and will ask ... if [patient] needs anything. If [patient] gets hungry before or after [significant other] lunch break, client states [patient] is able to prepare [self] canned soup and heat it up in the microwave. [Patient] also states [patient] is able to make [self] a sandwich." This logging failed to evidence discussion of possible discharge. 5. The Client/Facility logging dated 3/22/16 at 11:15 AM stated "Spoke with client's case manager. She stated she found a home care agency to take over. The company is Acti-Kare and services will begin 4/1/16. There is a		caregivers is identified prior to acceptingthe patient for admission. The patientwould not be accepted for admission if not 100% staffed per the physicianordered frequency. Further, during theintake process, a review of all current patients with similar services andgeographic location will be reviewed to ensure that admission of the newpatient would not adversely affect staffing options for current patient. If itis identified that current patients with similar services an geographiclocation will be at risk for staffing gaps, the new patient referral will bedeclined. Internal Office staff will be educated on this process by5/27/16. The DOCS/AM/Designee willprovide this education with attendance acknowledgment and respective documentsto be kept in the QI Binder. An office process will be developed, based on the currentMissed Shift Policy, in order to ensure that all missed shifts are documentedand supportive loggings will be entered. All internal office staff will be educated on the new process, includingexisting Missed Shifts Policy. The DOCS/AM/Designee will provide this educationwith attendance acknowledgment and respective documents to be kept in the QIBinder. To be completed by5/17/2016. In order to minimize the future recurrence of missed shifts,the	

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	possibility client will be discharged tomorrow. ... [Aging and In-Home Case Manager] is still trying to find a PA approved company that will provide the services. She stated she may have to increase client Attendant care to accommodate for therapy. Clarified we are still unable to staff permanently." The record failed to evidence the agency discharged the patient. 6. An email dated 3/23/16 from employee P to Ft. Wayne HH stated "[Patient] told me on the phone that [they] would like to stay on board with us and not change companies. I told [patient] that we have someone coming in from the [patient town] area but that I couldn't make any promises on whether or not the worker could staff [patient] and that I wouldn't know until after the interview. [Patient] said that [they] didn't care and that [they] wanted to stay on board with us." The record failed to evidence the agency followed its own discharge policy. 2. The agency's policy titled "Discharge," # MD-CL-013.9, dated 1/11/16 stated "5. Discharge Criteria: 5.1. Services will be discontinued when the patient/client meets one (1) or more of the following discharge criteria: ... 5.1.6. Available resources, services, or personnel are		Administrator/Clinical Manager and Accounts Manager/designee will implementand monitor a Recruitment Plan. Allinternal staff will be educated on this plan by Accounts Manager/designee withattendance acknowledgement and respective documents to be kept in the QIbinder. **Recruitment Plan:** Our recruitment plan includes a multi-faceted approach directed byAgency Recruiters. This approachincludes job postings to identify new candidates, previous candidate follow-upvia existing database, referrals through a renewed emphasis on employeeengagement, local community events, and resume database searches. Ongoing monitoring by Clinical Manager/Administratorand AM during weekly office meetings will allow for additional activities andexpansion of current activities where deemed necessary. Office will maintain anactive caregiver Float Pool effective 5/27/16. Office will contract with Maxim Staffing Solutions for potential utilizationof contractual caregiver pool by 5/27/16. **Phase one**: Agency will complete a 100% self-assessmentof the current patient census to determine if patient's needs are being met. Thisreview was completed on April 21, 2016 and May 26, 2016 and will continue on amonthly basis during the office monthly Quality	

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	inadequate for the continuing needs of the patient/client."		Improvement Committee meeting.If problematic areas are identified the Clinical Manager/Administrator/AM willinitiate our multi-faceted approach to narrow down our pool of candidates tothose who possess the skills, meet the availability required to provide ongoingcoverage and are strategically identified based on geographical location fromthe patient's home. **Phase two** of the plan is ongoing activity related torecruitment of caregivers. This ongoing plan is managed by expectationsof frequency related to activity. Agency Recruiters are responsible for recruitingfloat pool caregivers, creating new job postings, following up with existingcandidates, engaging with current employees to offer additional workopportunities to those who desire more hours, participate in local communityhealth related job fairs, contacting contracted staffing agencies and sourcecurrent resumes in our resume database. AM and/or designee carefullymonitor activity on a daily, weekly and monthly basis to ensure that activitystandards are met to support personnel needs. In addition to the Recruitment plan the Administrator andAccounts Manager/designee will implement the daily "Red Zone" meeting and weekly"Wednesday Clear" program to identify areas of concern and activity surroundingrecruitment and	

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			staffing issues as evidenced by meeting minutes. "Red Zone" is a daily meeting that occurs toidentify priorities and action items within the office and to ensure that theassociated team members have plans to address, complete, and follow up within atimely manner. "Wednesday Clear" is aproactive communication and planning process to identify any staffingconcern(s) and/or open visit/ shifts 10 days in advance, and then to developspecific action plan(s) to meet the patient needs, cover any open visit/ shift,and then to communicate with the patient and/or primary caregiver in a timelymanner. An office process will be developed, based on the currentDischarge Policy, in order to ensure that patient discharge will be initiatedwhen one or more discharge criteria is met per Company policy, includingongoing failure to substantially meet staffing requirements per physicianorders. In the event that we experience ongoing failure of our efforts tosubstantially meet a patient's scheduling needs, and available staff cannot beidentified, Agency will commence the discharge process. All internal officestaff will be educated on the new process, including existing Company Policy titled"Discharge" #MD-CL-013.9. The ClinicalManager/Account Manager/Designee will provide this	

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			education with attendanceacknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that the agency has adequately met Patient staffingneeds and ensure compliance with Company Discharge Policy. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur. Completion Date: 5/27/16	
N 0522 Bldg. 00	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 document review and interview, the agency failed to ensure home health aide visits were made as ordered by the physician and failed to ensure the home health aide followed physician orders for 1 of 4 records reviewed (# 2) receiving home health aide services; and failed to ensure orders for treatment were followed by the nurses for 1 of 10 records reviewed. (# 4)	N 0522	Patient #2 was discharged on 4/14/2016. Employee R wasre-educated on following the plan of care on 5/11/2016. An office process will be developed, based on the currentMissed Shift Policy, in order to ensure that all missed shifts are documentedand supportive loggings will be entered. All internal office staff will be educated on the new process, includingexisting Missed Shifts Policy. The	05/27/2016

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	Findings include 1. The record for patient # 2 was reviewed on 4/5/16. The start of care date was 12/18/15. The record contained a plan of care dated 12/17/15-2/14/16 with orders for HHA 3-5 days per week, 7 to 10 hours per week, for 60 days, plus 18 hours a month Attendant care, and 15 hours per month of Homemaker via waiver; HHA to check blood pressure and pulse daily and notify Clinical Supervisor if outside parameters- blood pressure to be no greater than 150/100 and not less than 100/60, Pulse to be no greater than 130 and no less than 70. The record failed to evidence the agency provided HHA services from 2/5/16 through 3/29/16 due to lack of available staff; failed to evidence the agency discharged the patient when it was unable to find staff from 2/5-3/27/15; and failed to evidence the HHA followed the plan of care as ordered. A. During interview on 4/5/16 at 2:00 PM, the Alternate Administrator stated the agency provided HHA services last week for patient #2, but this was the first time since 2/4 when employee K was pulled from the case. The Alternate Administrator stated this patient is currently receiving physical therapy		DOCS/AM/Designee will provide this educationwith attendance acknowledgment and respective documents to be kept in the QIBinder. To be completed by 5/17/2016. The current patient census was reviewed on 4/21/16 and againon 5/26/16 to determine if patient staffing needs are being met. This patient census review will be completedon a monthly ongoing basis as part of the office Quality Improvement Committeemeeting. Documentation of this reviewwill be maintained in the Quality Improvement Binder. When problematic staffingareas are identified, the office will adhere to the following process for thosepatients who are at risk of needs not being met: ·Recruiters will call all primary and secondarydirect caregivers to check their availability to meet the staffing requirementper the patient's plan of care. If theprimary and secondary caregivers are unavailable, qualified staff will beidentified from current caregiver roster, to include float pool staff andcontracted workers as explained below, and reviewed with the patient andprimary caregiver as an option to meet staffing need; if acceptable, the newstaff will receive a patient specific orientation from the ClinicalSupervisor/clinical designee prior to working the shift. Measures have been taken	

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	services as of 4/4/16, through Lutheran which is another Medicare provider, so HHA services here through Medicaid are on hold. B. During interview on 4/5/16 at 2:00 PM, the Administrative Officer stated for waiver patients, a 30 day discharge notice is required. C. During interview on 4/11/16 at 10:45 AM, the Alternate Administrator stated the agency had been providing wellness checks such as supervisory visits/comprehensive assessments/and recertification visits for the patient since they have been unable to staff a HHA since 2/4/16 until the end of March. The Alternate Administrator stated the agency has also not been able to have any nurses replace and cover HHA shifts due to lack of nurses availability. The Alternate Administrator stated the agency wrote an order to place HHA services on hold as of 3/31/16. The Alternate Administrator stated the patient's significant other has been providing care for the patient before work, at lunch, and after work. The Alternate Administrator stated that Maxim has been attempting recruiting efforts since 2/4/16, and that Aging and In-Home Services is looking for another home health agency for the patient.		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. ·A caregiver float pool will be developed by5/27/16 as a tertiary option to fill patient staffing needs. Float pool staff will be available for calloffs and other staffing gaps on an as needed basis. Float pool staff will only be utilized tocover patients for which they are qualified. Float pool staff will receive a patient specific orientation from theClinical Supervisor/clinical designee prior to working the shift. ·Measures have been taken by the Administrator toensure a contractual agreement with Maxim Staffing Solutions to assist withproviding a qualified caregiver in the event an open shift cannot be filled bythe Home Health Agency's own employee pool. If no staff is available, to include primary, secondary, tertiary andfloat pool, the agency will notify contracted agency for staffing options. If no staff available, the patient, primarycaregiver, physician and patient's casemanager are notified and alternate forms of care are discussed. All communications will be recorded in thesystem of record. If it is identifiedthat staffing unavailability will not be	

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	D. During interview on 4/18/16 at 9:15 AM, the Administrator stated she tried to get patient # 2 discharged due to not having staff available to provide care, but the advisory services of Maxim said not to discharge yet, attempt to find staff. The Administrator stated this patient is being moved to personal care only services, as the patient ended up telling them things that were not true, and the patient can do more for self than the agency was lead to believe, and the patient stated their significant other is able to help the patient. The Administrator stated Maxim has processes in place that have to be followed first, and that she cannot just do what needs to be done without checking first. The Administrator stated discharge is a last resort if we cannot find staff in to service a client. The Administrator stated patient #2 had said a company in New Haven was able to provide services in March, but the patient said no, as the patient requested to stay with Maxim. E. The clinical record failed to evidence the agency provided HHA services since 2/4/16. 1. Missed Visit/Shift Notifications were completed for: 2/5, 2/15, and 2/17/16, with reason "Declined Qualified Caregiver;" Client/Facility loggings		intermittent but long term, then therewill be increased recruitment efforts as identified in the recruitment strategyoutlined later in this response. ·If these increased efforts to staff the patientper the physician ordered frequency are not effective, then we will refer tothe discharge policy as we will have met one of the criteria for discharge thatstates available personnel are adequate for the continuing needs of theclient. ·The Administrator/designee will educate allInternal Office staff on this process by 5/27/16. This education will be maintained in theQuality Improvement binder. A n office intake process has been developed based on companypolicy titled “Acceptance and Admission” MD-CL-006.3 This process includes steps to ensure thatpatients are not accepted into service without the resources available toprovide care. During the intake processthe office referral team will evaluate all new referrals for staffing needs anda schedule of available, qualified caregivers is identified prior to acceptingthe patient for admission. The patientwould not be accepted for admission if not 100% staffed per the physicianordered frequency. Further, during theintake process, a review of all current patients with similar services andgeographic location will be reviewed to ensure that	

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	failed to evidence the agency had found staff to cover these dates. 2. Missed Visit/Shift Notifications were completed for: 2/8, 2/10, 2/11, 2/12, 2/13, 2/22, 2/24, 2/26, 2/29, 3/2, 3/4, 3/7, 3/9, 3/11, 3/14, 3/16, and 3/18/16 with reason "employee availability." Client/Facility loggings failed to evidence the agency had found staff to cover these dates. 3. The Client/Facility logging dated 3/9/16 at 11:25 AM, stated "Informed [nurse from Dr. office] client's recertification ends 4/14/16 and if we are unable to provide staff by then, more than likely we will have to discharge. Informed her of recruiting efforts, and case manager is aware and is attempting to find client a different home care agency that is able to provide staff in the ... area." The record failed to evidence the agency had found staff to cover and failed to evidence the agency planned to discharge before 4/14/16. 4. The Client/Facility logging dated 3/22/16 at 1:45 PM was a note by the Administrator, who had made a visit to the patient. This note stated "3/18/16 ... When asked how [patient] was able to shower and get dressed, client stated [patient] gets up at 5 am with [significant		admission of the new patientwould not adversely affect staffing options for current patient. If it isidentified that current patients with similar services an geographic locationwill be at risk for staffing gaps, the new patient referral will bedeclined. The Administrator/designee will educate all Internal Officestaff on this process by 5/27/16. Thiseducation will be maintained in the Quality Improvement binder. An office process will be developed, based on the currentMissed Shift Policy, in order to ensure that all missed shifts are documentedand supportive loggings will be entered. All internal office staff will be educated on the new process, includingexisting Missed Shifts Policy. The DOCS/AM/Designee will provide this educationwith attendance acknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/17/2016. In order to minimize the future recurrence of missed shifts,the Administrator/Clinical Manager and Accounts Manager/designee will implementand monitor a Recruitment Plan. All internal staff will be educated on this planby Accounts Manager/designee with attendance acknowledgement and respectivedocuments to be kept in the QI binder. **Recruitment Plan:** Our	

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	other] before [significant other] goes to work and [significant other] helps [patient] shower and get dressed. During the visit, observed client walking to the bathroom. ... Client was able to use the bathroom alone without assistance. When asked how [patient] was able to get [their] meals during the day, client replied that [significant other] comes home on lunch every day to let the dog outside and will ask ... if [patient] needs anything. If [patient] gets hungry before or after [significant other] lunch break, client states [patient] is able to prepare [self] canned soup and heat it up in the microwave. [Patient] also states [patient] is able to make [self] a sandwich." This logging failed to evidence discussion of possible discharge. 5. The Client/Facility logging dated 3/22/16 at 11:15 AM stated "Spoke with client's case manager. She stated she found a home care agency to take over. The company is Acti-Kare and services will begin 4/1/16. There is a possibility client will be discharged tomorrow. ... [Aging and In-Home Case Manager] is still trying to find a PA approved company that will provide the services. She stated she may have to increase client Attendant care to accommodate for therapy. Clarified we are still unable to staff permanently."		recruitment plan includes a multi-faceted approach directed byAgency Recruiters. This approachincludes job postings to identify new candidates, previous candidate follow-upvia existing database, referrals through a renewed emphasis on employeeengagement, local community events, and resume database searches. Ongoing monitoring by ClinicalManager/Administrator and AM during weekly office meetings will allow foradditional activities and expansion of current activities where deemednecessary. Office will maintain an active caregiver Float Pool effective5/27/16. Office will contract with MaximStaffing Solutions for potential utilization of contractual caregiver pool by5/27/16. **Phase one**: Agency will complete a 100% self-assessmentof the current patient census to determine if patient's needs are being met.This review was completed on 4/21/2016 and 5/26/2016, and will continueon a monthly basis during the office monthly Quality Improvement Committeemeeting. If problematic areas are identified the ClinicalManager/Administrator/AM will initiate our multi-faceted approach to narrowdown our pool of candidates to those who possess the skills, meet theavailability required to provide ongoing coverage and are	

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	The record failed to evidence the agency discharged the patient. 6. An email dated 3/23/16 from employee P to Ft. Wayne HH stated "[Patient] told me on the phone that [they] would like to stay on board with us and not change companies. I told [patient] that we have someone coming in from the [patient town] area but that I couldn't make any promises on whether or not the worker could staff [patient] and that I wouldn't know until after the interview. [Patient] said that [they] didn't care and that [they] wanted to stay on board with us." The record failed to evidence the agency followed its own discharge policy. 7. The Aide Weekly Note dated 3/28/16 by employee R, failed to evidence the HHA checked the patient's blood pressure. 2. The record for patient # 4 was reviewed on 4/12/16. The start of care for patient # 4 was 10/5/09. The Plan of care dated 3/2-4/30/16 contained orders for skilled nursing SN 4-6 days per week, 26-43 hours per week for 60 days. SN orders included flush g-tube with up to 250 mL [milliliters] of water as needed, before and after medications and as needed per clogged tube. The record		strategicallyidentified based on geographical location from the patient's home. **Phase two** of the plan is ongoing activity related torecruitment of caregivers. This ongoing plan is managed by expectationsof frequency related to activity. Agency Recruiters are responsible forrecruiting float pool caregivers, creating new job postings, following up withexisting candidates, engaging with current employees to offer additional workopportunities to those who desire more hours, participate in local communityhealth related job fairs, contacting contracted staffing agencies and sourcecurrent resumes in our resume database. AM and/or designee carefully monitoractivity on a daily, weekly and monthly basis to ensure that activity standardsare met to support personnel needs. In addition to the Recruitment plan the Administrator andAccounts Manager/designee will implement daily meetings including "Red Zone"and "Wednesday Clear" to identify areas of concern and activity surroundingrecruitment and staffing issues as evidenced by weekly meeting minutes. "Red Zone" is a daily meeting that occurs toidentify priorities and action items within the office and to ensure that theassociated team members have plans to address, complete, and follow up within atimely manner. "Wednesday Clear" is aproactive	

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	failed to evidence the nurses followed the water orders. A. The Nursing Flow Sheet dated 3/2/16 Intake section evidenced the nurse documented 350 cc [cubic centimeters] flush at 12:10 PM. B. The Nursing Flow Sheet dated 3/4/16 Intake section evidenced the nurse documented 350 cc flushes at 1:00 and 6:45 PM. C. The Nursing Flow Sheet dated 3/9/16 Intake section evidenced the nurse documented 350 cc flush at 1:00 PM. D. The Nursing Flow Sheet dated 3/11/16 Intake section evidenced the nurse documented 350 cc flushes at 11:05 AM, 1:00 PM, and 300 cc flush at 2:15 PM. E. The Nursing Flow Sheet dated 3/12/16 Intake section evidenced the nurse documented 350 cc flush at 11:10 AM. F. The Nursing Flow Sheet dated 3/13/16 Intake section evidenced the nurse documented 350 cc flushes at 11:20 AM and 12:40 PM. G. The Nursing Flow Sheet dated		communication and planning process to identify any staffingconcern(s) and/or open visit/ shifts 10 days in advance, and then to developspecific action plan(s) to meet the patient needs, cover any open visit/ shift,and then to communicate with the patient and/or PCG in a timely manner. An office process will be developed, based on the currentDischarge Policy, in order to ensure that patient discharge will be initiatedwhen one or more discharge criteria is met per Company policy, includingongoing failure to substantially meet staffing requirements per physicianorders. In the event that we experience ongoing failure of our efforts tosubstantially meet a patient's scheduling needs, and available staff cannot beidentified, Agency will commence the discharge process. All internal officestaff will be educated on the new process, including existing Company Policytitled "Discharge" #MD-CL-013.9. TheClinical Manager/Account Manager/Designee will provide this education withattendance acknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that the agency has	

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	3/14/16 Intake section evidenced the nurse documented 350 cc flushes at 11:15 AM and 2:15 PM. H. The Nursing Flow Sheet dated 3/15/16 Intake section evidenced the nurse documented 350 cc flushes at 11:30 AM and 12:50 PM, and a 300 cc flush at 2:05 PM. I. The Nursing Flow Sheet dated 3/15/16 Intake section evidenced the nurse documented 350 cc flushes at 11:00 AM and 12:30 PM, and a 300 cc flush at 2:00 PM. J. The Nursing Flow Sheet dated 3/18/16 Intake section evidenced the nurse documented 300 cc flush at 2:40 PM. K. The Nursing Flow Sheet dated 3/19/16 Intake section evidenced the nurse documented 350 cc flushes at 11:40 AM and 12:30 PM. L. The Nursing Flow Sheet dated 3/20/16 Intake section evidenced the nurse documented 350 cc flushes at 11:00 AM and 12:30 PM. M. The Nursing Flow Sheet dated 3/21/16 Intake section evidenced the nurse documented 400 cc flush at 11:10		adequately met Patient staffingneeds and ensure compliance with Company Discharge Policy. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur. Completion Date: 5/27/16 Direct Caregivers for Patient #4 will be re-educated onfollowing physician's orders, to include water flushes per the plan of care. 100% review of documentation for patient # 4will be performed for 30 days to ensure that all orders for treatment,including water flushes, are followed by the nurses providing care. All skilled nursing staff was assigned Annual ComplianceTraining which includes the importance of documentation and the plan of care,on 5/2/16. Ongoing nurse flowsheets and aide weekly notes for 25% ofthe patient census will be reviewed weekly by the Clinical Supervisors as apart of focused documentation review to ensure that direct care staff arefollowing physician orders. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that direct caregivers, to include home healthaides, LPNs and RNs, are following the physician orders. The Clinical Manager is responsible for monitoring	

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	AM, and 350 cc flush at 12:30 PM. N. The Nursing Flow Sheet dated 3/22/16 Intake section evidenced the nurse documented 400 cc flush at 11:10 AM, and 350 cc flush at 12:30 PM. O. The Nursing Flow Sheet dated 3/23/16 Intake section evidenced the nurse documented 400 cc flush at 11:15 AM, and 350 cc flush at 12:45 PM. P. The Nursing Flow Sheet dated 3/25/16 Intake section evidenced the nurse documented 350 cc flush at 11:00 AM and 12:45 PM. Q. The Nursing Flow Sheet dated 3/27/16 Intake section evidenced the nurse documented 350 cc flush at 11:10 AM and 12:30 PM. R. The Nursing Flow Sheet dated 3/28/16 Intake section evidenced the nurse documented 350 cc flush at 11:00 AM and 12:35 PM. S. The Nursing Flow Sheet dated 3/29/16 Intake section evidenced the nurse documented 350 cc flush at 11:10 AM and 12:45 PM. T. The Nursing Flow Sheet dated 3/30/16 Intake section evidenced the		thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur. Completion Date: 5/19/16 **G156/G159 and N524 G-159 Plan of CareAND N524 410 IAC 17-13-1(a)(1) (PatientCare)** The Clinical Manager will re-educate all Internal Clinical Supervisors,including Employee J, on Company Policy "Home Health Certificate and Plan(s) ofCare" #HH-CL-007.6 to include the requirement to ensure all durable medicalequipment in the home and used by the patient is included on the Plan ofCare. Attendance will be recorded andfiled in the QI Binder along with supporting documentation. To be completed by5/19/2016. A supplemental order for patient #6 adding the appropriatepatient durable medical equipment was obtained and signed by the patient'sphysician on 4/18/16. The Plan of Care forPatient #6 was updated to include the all durable medical equipment used by thepatient. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that all durable medical equipment used by thepatient is included in the plan of care. Additionally a minimum of 5 home visits will be conducted as part of thequarterly audit to ensure that all durable medical equipment in the patient'shome is	

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	157591	A. BUILDING 00 B. WING	04/19/2016

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	nurse documented 350 cc flush at 11:00 AM and 12:30 PM. U. The Nursing Flow Sheet dated 4/2/16 Intake section evidenced the nurse documented 350 cc flush at 11:35 AM and 12:50 PM. 3. The agency's job description titled "Registered Nurse," stated "Performance Standards: ... 6. ... Administers medications and treatment as prescribed by the physician." 4. The agency's job description titled "Licensed Vocational Nurse/Licensed Practical Nurse," stated "Performance Standards: 1. Each shift or visit reflects the provision of skilled nursing care rendered in accordance with physician's orders. ... 2. ... b. Performs specific treatments and medication administration in accordance with physician orders." 5. The agency's policy titled "Missed Shift/Visit-Delaware Physician Care," # SOP-MD-CL-016 DEa, dated 1/6/2014 stated "1.0 Maintain Adequate Resource Pool, 2.0 Notify Patient and/or Family of Process to Follow in the Event of a Reschedule and/or Staff Failure to Appear, 3.0 Receive Notification That Assigned Staff Unable to Meet and/or Fulfill Scheduled Shift, 4.0 Office		included on the plan of care. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur. Completion Date: 5/27/16	

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	Contacts Qualifies Alternate Staff, 5.0 Determine if Available Resources to Cover Shift Are Not Found in the Available Office Pool, 6.0 Determine if Shift is Unable to Be Covered By Alternate Resources, 7.0 Updated Schedule to Missed Shift, 8.0 Transmit Weekly Payroll. ... Comments ... Supplemental resources will be available to address the patient care needs when regularly scheduled staff cannot meet their scheduled shift. ... Office Operations should consider establishing contractual relationships with staffing agencies or alternate home health agencies to provide supplemental qualified staff when employees are not available to cover scheduled and/or unscheduled absences. Qualified administrative and clinical staff will be available to respond to patient and/or Direct Care Staff calls as outlined in policy: HH-CL-019: On-Call Coverage. ... 2.0 ... Comments, ... The Clinical staff will provide written and verbal notification during the admission visit that gaps in Covered Personnel Care/Attendant Care Services may be filled with a back-up worker. ... 4.0 ... Comments, Consider alternate staffs who are regularly assigned to determine if they are available to cover the open shift. If patient familiar staff is unavailable, expand search to qualified staff which			

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	meet qualifications and competencies for the patient. ... 6.0 ... Comments, If all backup options fail to identify a resource, the Office Clinical Leader and physician will be notified through communication and documented in the medical record."			
N 0524 Bldg. 00	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.			

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	(vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on observation, document review, and interview, the agency failed to ensure the plans of care included all durable medical equipment (DME) used by the patients for 1 of 5 observations. (#6) Findings include 1. The clinical record for patient #6 was reviewed on 4/14/16. The start of care date was 12/11/15. The plan of care dated 4/9-6/7/16 contained orders for HHA 3-5 days per week, 9-15 hours per month for 60 days. The plan of care failed to include all DME used by the patient. A. During observation of patient # 6 on 4/13/16 at 2:00 PM, DME in the home included a life line button and shower chair. The Plan of Care failed to include these DME. B. During interview on 4/14/16 at 1:20 PM, employee J (Alternate Nurse	N 0524	The Clinical Manager will re-educate all Internal Clinical Supervisors,including Employee J, on Company Policy "Home Health Certificate and Plan(s) ofCare" #HH-CL-007.6 to include the requirement to ensure all durable medicalequipment in the home and used by the patient is included on the Plan ofCare. Attendance will be recorded andfiled in the QI Binder along with supporting documentation. To be completed by5/19/2016. A supplemental order for patient #6 adding the appropriatepatient durable medical equipment was obtained and signed by the patient'sphysician on 4/18/16. The Plan of Care forPatient #6 was updated to include the all durable medical equipment used by thepatient. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that all durable medical equipment used by thepatient is	05/19/2016

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	Supervisor) stated she did not realize the patient had a shower chair. 2. The agency 's policy titled "Home Health Certification and Plan(s) of Care," # HH-CL-007.6, dated 6/22/15 stated "Procedure ... 5.3. The Plan of Care shall include, but not be limited to: ... 5.3.4. Listing of equipment and supplies."		included in the plan of care. Additionally a minimum of 5 home visits will be conducted as part of thequarterly audit to ensure that all durable medical equipment in the patient'shome is included on the plan of care. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur.	
N 0537 Bldg. 00	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on document review and interview, the agency failed to ensure the physician orders for treatment were followed by the nurses for 2 of 10 records reviewed (# 1, and 4). Findings include 1. The record for patient # 4 was reviewed on 4/12/16. The start of care for patient # 4 was 10/5/09. The Plan of care dated 3/2-4/30/16 contained orders for skilled nursing SN 4-6 days per week, 26-43 hours per week for 60 days. SN orders included flush g-tube with up to 250 mL [milliliters] of water as needed, before and after medications and as	N 0537	Direct Caregivers for Patient #4 will be re-educated onfollowing physician's orders, to include water flushes per the plan of care. 100% review of documentation for patient # 4 willbe performed for 30 days to ensure that all orders for treatment, includingwater flushes, are followed by the nurses providing care. Skilled Nursing Direct Caregivers for Patient #1 will bere-educated on following physician's orders, to include suprapubic catheterchange, assessing vital signs and assessing pain as ordered on the plan ofcare. 100% review of documentation forpatient # 1 will be performed for 30 days to ensure that all orders	05/19/2016

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	needed per clogged tube. The record failed to evidence the nurses followed the water orders. A. The Nursing Flow Sheet dated 3/2/16 Intake section evidenced the nurse documented 350 cc [cubic centimeters] flush at 12:10 PM. B. The Nursing Flow Sheet dated 3/4/16 Intake section evidenced the nurse documented 350 cc flushes at 1:00 and 6:45 PM. C. The Nursing Flow Sheet dated 3/9/16 Intake section evidenced the nurse documented 350 cc flush at 1:00 PM. D. The Nursing Flow Sheet dated 3/11/16 Intake section evidenced the nurse documented 350 cc flushes at 11:05 AM, 1:00 PM, and 300 cc flush at 2:15 PM. E. The Nursing Flow Sheet dated 3/12/16 Intake section evidenced the nurse documented 350 cc flush at 11:10 AM. F. The Nursing Flow Sheet dated 3/13/16 Intake section evidenced the nurse documented 350 cc flushes at 11:20 AM and 12:40 PM.		fortreatment, including suprapubic catheter change, vital signs and painassessment, are followed and documented by the nurses providing care. All skilled nursing staff was assigned Annual ComplianceTraining which includes the importance of documentation and the plan of care,on 5/2/16. Ongoing Nursing flowsheets for 25% of the patient censuswill be reviewed weekly by the Clinical Supervisors as a part of focuseddocumentation review to ensure that direct care staff are following physicianorders. To ensure this alleged deficiency does not recur, 10clinical records or 10% of all clinical records, whichever is greater, will beaudited quarterly to ensure that direct caregivers, including LPNs and RNs, arefollowing the physician orders. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur.	

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	G. The Nursing Flow Sheet dated 3/14/16 Intake section evidenced the nurse documented 350 cc flushes at 11:15 AM and 2:15 PM. H. The Nursing Flow Sheet dated 3/15/16 Intake section evidenced the nurse documented 350 cc flushes at 11:30 AM and 12:50 PM, and a 300 cc flush at 2:05 PM. I. The Nursing Flow Sheet dated 3/15/16 Intake section evidenced the nurse documented 350 cc flushes at 11:00 AM and 12:30 PM, and a 300 cc flush at 2:00 PM. J. The Nursing Flow Sheet dated 3/18/16 Intake section evidenced the nurse documented 300 cc flush at 2:40 PM. K. The Nursing Flow Sheet dated 3/19/16 Intake section evidenced the nurse documented 350 cc flushes at 11:40 AM and 12:30 PM. L. The Nursing Flow Sheet dated 3/20/16 Intake section evidenced the nurse documented 350 cc flushes at 11:00 AM and 12:30 PM. M. The Nursing Flow Sheet dated 3/21/16 Intake section evidenced the			

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	nurse documented 400 cc flush at 11:10 AM, and 350 cc flush at 12:30 PM. N. The Nursing Flow Sheet dated 3/22/16 Intake section evidenced the nurse documented 400 cc flush at 11:10 AM, and 350 cc flush at 12:30 PM. O. The Nursing Flow Sheet dated 3/23/16 Intake section evidenced the nurse documented 400 cc flush at 11:15 AM, and 350 cc flush at 12:45 PM. P. The Nursing Flow Sheet dated 3/25/16 Intake section evidenced the nurse documented 350 cc flush at 11:00 AM and 12:45 PM. Q. The Nursing Flow Sheet dated 3/27/16 Intake section evidenced the nurse documented 350 cc flush at 11:10 AM and 12:30 PM. R. The Nursing Flow Sheet dated 3/28/16 Intake section evidenced the nurse documented 350 cc flush at 11:00 AM and 12:35 PM. S. The Nursing Flow Sheet dated 3/29/16 Intake section evidenced the nurse documented 350 cc flush at 11:10 AM and 12:45 PM. T. The Nursing Flow Sheet dated			

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	3/30/16 Intake section evidenced the nurse documented 350 cc flush at 11:00 AM and 12:30 PM. U. The Nursing Flow Sheet dated 4/2/16 Intake section evidenced the nurse documented 350 cc flush at 11:35 AM and 12:50 PM. 2. The record for patient #1 was reviewed on 4/14/16. The Plan of Care dated 3/29-5/27/16 contained orders for Home Health Aide (HHA) 5-7 days a week, 17-28 hours per week for 60 days, and skilled nursing (SN) every other day for bowel program and monthly suprapubic catheter change for 60 days, SN orders: observation and assessment every shift for signs of distress including Vital Signs (temperature, pulse, respirations, and blood pressure), assess pain. A. The record failed to evidence the suprapubic catheter had been changed since 2/21/16. B. During interview on 4/15/16 at 9:00 AM, employee F (Clinical Supervisor) stated the patient said the next catheter change is due this Sunday and the last was on 3/20/16. C. The Skilled Nursing Note dated			

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	3/20/16 failed to evidence the suprapubic catheter had been changed. D. The record failed to evidence the nurses followed the plan of care and checked vital signs every shift. The SN Notes dated 2/21, 3/20, 3/26, 3/28, 3/30, 4/1, 4/7, and 4/9/16 failed to evidence the vital signs were assessed; the nurses had documented "N/A [not applicable]." E. The record failed to evidence the nurses followed the plan of care and assessed pain every shift. The SN Notes dated 2/21, 3/20, 3/26, 4/7, and 4/9/16 failed to evidence pain was assessed; the nurses had documented "N/A [not applicable]." 3. The agency's job description titled "Registered Nurse," stated "Performance Standards: ... 6. ... Administers medications and treatment as prescribed by the physician." 4. The agency's job description titled "Licensed Vocational Nurse/Licensed Practical Nurse," stated "Performance Standards: 1. Each shift or visit reflects the provision of skilled nursing care rendered in accordance with physician's orders. ... 2. ... b. Performs specific treatments and medication administration in accordance with physician orders."			

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N 0544 Bldg. 00	410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on record review and interview, the agency failed to ensure the nurse documented accurately for 1 of 10 records reviewed, failed to ensure the nurse documented a change in condition for 3 of 10 clinical records reviewed. (#1, 4, 5) Findings include 1. The clinical record for patient # 5 was reviewed on 3/18/16. Start of care date was 3/10/16. The record contained a plan of care dated 3/10-5/8/16 with diagnosis of Chronic Respiratory failure with hypoxia, Dependence on respirator (ventilator), and Encounter for attention to tracheostomy and gastrostomy. The plan of care contained orders for Skilled Nursing (SN) services 12-20 hours per day, 5-7 days per week for 60 days. General orders for skilled observation and assessment every shift and as needed for signs of distress including vital signs (temperature, pulse, respirations, and	N 0544	The Clinical Manager will re-educate all ClinicalSupervisors, including Employee E, on company policy "Patient/ClientRecord: Content and Requirements"#MD-CL-002.5 as well as the requirement to conduct and document a complete andthorough Comprehensive Assessment and OASIS. The DOCS/AM/Designee will provide this education with attendanceacknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. Ongoing the Clinical Manager/clinical designeewill conduct a review of Comprehensive Assessments and OASIS completed atRecertification to ensure that the assessment was thoroughly and accuratelydocumented. Patient #5 was discharged on 3/21/16. All skilled nursing staff, including Employee B, wasassigned Annual Compliance Training which includes the importance of documentationand the plan of care, on 5/2/16. An office process will be developed,	05/19/2016

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	oxygen levels) ... Respiratory orders including Astral 150 Ventilator to be worn 24 hours/day 7 days a week. A. The Nursing Flow Sheet dated 3/16/16 from 6:45 AM-2:05 PM charting stated "1:15 PM." Nothing was charted at 1:15 PM. The record failed to evidence the patient change in condition and actions taken by the nurse. B. During interview on 3/18/16 at 3:50 PM, the Administrator stated that the legal department told employee B (Licensed Practical Nurse) not to chart the incident until the investigation was complete but the agency did call him in for interview to begin the investigation that same day. C. During interview on 3/18/16 at 4:50 PM, per telephone, employee B stated he did not document the incident from 3/16/16 at 1:15 due to the agency told him not to. 2. The record for patient #1 was reviewed on 4/14/16. The Plan of Care dated 3/29-5/27/16 contained orders for Home Health Aide (HHA) 5-7 days a week, 17-28 hours per week for 60 days, and skilled nursing (SN) every other day for bowel program and monthly suprapubic catheter change for 60 days,		based on thePatient/Client Record: Content and Requirements policy, to ensure that allclinical documentation completed by the direct caregivers, to include seizuredocumentation, is turned in to the office weekly. This process will include a tracking systemmanaged by the Field Support Team which includes a 100% of clinicaldocumentation that is turned in weekly by direct caregivers to ensure that allclinical documentation has been submitted to the office. The Field Support Team and ClinicalSupervisors will be educated on the new process, including existing Company Policytitled “Patient/Client Record: Content and Requirements” #MD-CL-002.5. TheClinical Manager/Field Support Manager/Designee will provide this educationwith attendance acknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. All seizure records for Patient #4 are filed in thepatient’s Medical Record. DirectCaregivers for Patient #4 will be re-educated on the requirement to turn in allclinical documentation, including seizure records, weekly. To ensure this alleged deficiency does not recur, 10 clinicalrecords or 10% of all clinical records, whichever is greater, will be auditedquarterly to ensure that all clinical documentation has been turned in	

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	SN orders: observation and assessment every shift for signs of distress including Vital Signs (temperature, pulse, respirations, and blood pressure), assess pain. A. The Outcome Assessment and Information Set (OASIS) document for recertification dated 3/26/16 failed to evidence the information collected reflected the patient status. The section titled "(M1620) Bowel Incontinence Frequency" failed to evidence the patient was on a bowel regimen/program. B. During interview on 4/15/16 at 9:00 AM, employee E (Clinical Supervisor) stated that was a mistake that she failed to mark the patient was on a bowel program. 3. The record for patient # 4 was reviewed on 4/12/16. The start of care for patient # 4 was 10/5/09. The Plan of care dated 3/2-4/30/16 contained orders for skilled nursing SN 4-6 days per week, 26-43 hours per week for 60 days. SN orders included flush g-tube with up to 250 mL [milliliters] of water as needed, before and after medications and as needed per clogged tube. The record failed to evidence seizures had been documented by the nurse.		to theoffice and filed in the Medical Record. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur.	

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	157591	A. BUILDING 00 B. WING	04/19/2016

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	A. The Supervisory Visit Note dated 3/30/16 stated "mild seizure this morning. 2 seizures last week." B. The Nursing Flow Sheet dated 3/30/16 failed to evidence the nurse documented a seizure. C. During interview on 4/12/16 at 11:45 AM, employee J (Alternate Nursing Supervisor) stated the nurses document seizures on the seizure record in the homes. D. During home visit observation on 4/13/16 at 9:30 AM, the seizure documentation was found in the patient home record, but had not been turned in to the agency. During interview at 9:30 AM, employee J stated these are to be turned in with weekly documentation. 4. The agency's policy titled "Patient/Client Record: Content and Requirements," # MD-CL-002.5, dated 10/5/15 stated "3.2. A patient/client record will be maintained for each patient/client receiving care. The patient/client record will contain sufficient information to: ... 3.2.3. Accurately document care provided and outcome(s) ... 3.3. All documentation shall be completed as care is provided no later than the end of the shift/visit. 3.4.			

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	All documentation will be submitted to the office within seven (7) days of the last shift/visit noted on the form. ... 3.4.2. Documentation will be filed in the patient/client record within 14 days of the shift/visit (last shift/visit if a multiple dated form) and/or assessment. ... 4. Documentation Guidelines: ... 4.4. Entries shall include the date (month/date/year) and the time (HH:MM) the care/service was provided." The agency failed to follow this policy. 5. The agency's job description titled "Registered Nurse," stated "Performance Standards: ... 6. ... Administers medications and treatment as prescribed by the physician." 6. The agency's job description titled "Licensed Vocational Nurse/Licensed Practical Nurse," stated "Performance Standards: 1. Each shift or visit reflects the provision of skilled nursing care rendered in accordance with physician's orders. ... 2. ... b. Performs specific treatments and medication administration in accordance with physician orders."			

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N 0608 Bldg. 00	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review and interview, the agency failed to ensure all documentation was complete, accurate, and in the patient record for 4 of 10 clinical records reviewed. (# 1, 2, 4, 5) Findings include 1. The clinical record for patient # 5 was reviewed on 3/18/16. Start of care date was 3/10/16. The record contained a plan of care dated 3/10-5/8/16 with diagnosis of Chronic Respiratory failure with hypoxia, Dependence on respirator (ventilator), and Encounter for attention to tracheostomy and gastrostomy. The	N 0608	The Clinical Manager will re-educate all ClinicalSupervisors, including Employee E, on company policy "Patient/ClientRecord: Content and Requirements"#MD-CL-002.5 as well as the requirement to conduct and document a complete andthorough Comprehensive Assessment and OASIS. The DOCS/AM/Designee will provide this education with attendanceacknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. Ongoing the Clinical Manager/clinical designeewill conduct a review of Comprehensive Assessments and OASIS completed atRecertification to ensure that the assessment was thoroughly and	05/19/2016

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	plan of care contained orders for Skilled Nursing (SN) services 12-20 hours per day, 5-7 days per week for 60 days. General orders for skilled observation and assessment every shift and as needed for signs of distress including vital signs (temperature, pulse, respirations, and oxygen levels) ... Respiratory orders including Astral 150 Ventilator to be worn 24 hours/day 7 days a week. A. The Nursing Flow Sheet dated 3/16/16 from 6:45 AM-2:05 PM charting stated "1:15 PM." Nothing was charted at 1:15 PM. The record failed to evidence the patient change in condition and actions taken by the nurse. B. During interview on 3/18/16 at 3:50 PM, the Administrator stated that the legal department told employee B (Licensed Practical Nurse) not to chart the incident until the investigation was complete but the agency did call him in for interview to begin the investigation that same day. C. During interview on 3/18/16 at 4:50 PM, per telephone, employee B stated he did not document the incident from 3/16/16 at 1:15 due to the agency told him not to. 2. The record for patient #1 was		accuratelydocumented. Patient #5 was discharged on 3/21/16. All skilled nursing staff, including Employee B, wasassigned Annual Compliance Training which includes the importance of documentationand the plan of care, on 5/2/16. An office process will be developed, based on thePatient/Client Record: Content and Requirements policy, to ensure that allclinical documentation completed by the direct caregivers, to include seizuredocumentation, is turned in to the office weekly. This process will include a tracking systemmanaged by the Field Support Team which includes a 100% of clinicaldocumentation that is turned in weekly by direct caregivers to ensure that allclinical documentation has been submitted to the office. The Field Support Team and ClinicalSupervisors will be educated on the new process, including existing Company Policytitled “Patient/Client Record: Content and Requirements” #MD-CL-002.5. TheClinical Manager/Field Support Manager/Designee will provide this educationwith attendance acknowledgment and respective documents to be kept in the QI Binder. To be completed by 5/19/2016. All seizure records for Patient #4 are filed in thepatient’s Medical Record.	

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	reviewed on 4/14/16. The Plan of Care dated 3/29-5/27/16 contained orders for Home Health Aide (HHA) 5-7 days a week, 17-28 hours per week for 60 days, and skilled nursing (SN) every other day for bowel program and monthly suprapubic catheter change for 60 days, SN orders: observation and assessment every shift for signs of distress including Vital Signs (temperature, pulse, respirations, and blood pressure), assess pain. A. The Outcome Assessment and Information Set (OASIS) document for recertification dated 3/26/16 failed to evidence the information collected reflected the patient status. The section titled "(M1620) Bowel Incontinence Frequency" failed to evidence the patient was on a bowel regimen/program. B. During interview on 4/15/16 at 9:00 AM, employee E (Clinical Supervisor) stated that was a mistake that she failed to mark the patient was on a bowel program. C. The record failed to evidence the suprapubic catheter had been changed since 2/21/16. D. During interview on 4/15/16 at 9:00 AM, employee F (Clinical		DirectCaregivers for Patient #4 will be re-educated on the requirement to turn in allclinical documentation, including seizure records, weekly. To ensure this alleged deficiency does not recur, 10 clinicalrecords or 10% of all clinical records, whichever is greater, will be auditedquarterly to ensure that all clinical documentation has been turned in to theoffice and filed in the Medical Record. The Clinical Manager is responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and doesnot recur.	

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	Supervisor) stated the patient said the next catheter change is due this Sunday and the last was on 3/20/16. E. The Skilled Nursing Note dated 3/20/16 failed to evidence the suprapubic catheter had been changed. F. The record failed to evidence the nurses followed the plan of care and checked vital signs every shift. The SN Notes dated 2/21, 3/20, 3/26, 3/28, 3/30, 4/1, 4/7, and 4/9/16 failed to evidence the vital signs were assessed; the nurses had documented "N/A [not applicable]." G. The record failed to evidence the nurses followed the plan of care and assessed pain every shift. The SN Notes dated 2/21, 3/20, 3/26, 4/7, and 4/9/16 failed to evidence pain was assessed; the nurses had documented "N/A [not applicable]." 3. The record for patient # 4 was reviewed on 4/12/16. The start of care for patient # 4 was 10/5/09. The Plan of care dated 3/2-4/30/16 contained orders for skilled nursing SN 4-6 days per week, 26-43 hours per week for 60 days. SN orders included flush g-tube with up to 250 mL [milliliters] of water as needed, before and after medications and as needed per clogged tube. The record			

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	failed to evidence seizures had been documented by the nurse. A. The Supervisory Visit Note dated 3/30/16 stated "mild seizure this morning. 2 seizures last week." B. The Nursing Flow Sheet dated 3/30/16 failed to evidence the nurse documented a seizure. C. During interview on 4/12/16 at 11:45 AM, employee J (Alternate Nursing Supervisor) stated the nurses document seizures on the seizure record in the homes. D. During home visit observation on 4/13/16 at 9:30 AM, the seizure documentation was found in the patient home record, but had not been turned in to the agency. During interview at 9:30 AM, employee J stated these are to be turned in with weekly documentation. 4. The record for patient # 2 was reviewed on 4/5/16. The start of care date was 12/18/15. The Plan of Care dated 2/15-4/14/16 contained orders for HHA 3-5 days per week, 6-10 hours per week for 60 days. HHA to check blood pressure and pulse daily and notify Clinical Supervisor if outside parameters-blood pressure to be no greater than			

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	150/100 and not less than 100/60, Pulse to be no greater than 130 and no less than 70. The clinical record failed to evidence the HHA followed the plan of care as ordered and documented vital signs. A. The Aide Weekly Note dated 3/28/16 by employee R, failed to evidence the HHA checked the patient's blood pressure. 5. The agency's policy titled "Patient/Client Record: Content and Requirements," # MD-CL-002.5, dated 10/5/15 stated "3.2. A patient/client record will be maintained for each patient/client receiving care. The patient/client record will contain sufficient information to: ... 3.2.3. Accurately document care provided and outcome(s) ... 3.3. All documentation shall be completed as care is provided no later than the end of the shift/visit. 3.4. All documentation will be submitted to the office within seven (7) days of the last shift/visit noted on the form. ... 3.4.2. Documentation will be filed in the patient/client record within 14 days of the shift/visit (last shift/visit if a multiple dated form) and/or assessment. ... 4. Documentation Guidelines: ... 4.4. Entries shall include the date (month/date/year) and the time (HH:MM) the care/service was provided."			

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