

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157684	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021
NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP COD 6612 E 75TH ST SUITES 400 INDIANAPOLIS, IN 46250		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 0000 Bldg. 00	<p>This visit was for an State Relicensure survey with 4 complaints of a home health provider.</p> <p>Survey Dates: 05/10/21 to 05/13/2021</p> <p>Facility ID: 002773</p> <p>Complaint #: IN00191185 - Substantiated. State deficiencies were cited.</p> <p>IN00196069 - Substantiated. State deficiencies were cited.</p> <p>IN00301849 - Substantiated. No State deficiencies were cited.</p> <p>IN00300669 - Substantiated. State deficiencies were cited.</p> <p>Quality Review on 6/10/21 by Area 2</p>	N 0000	<p>By submitting this POC the agency does not admit the allegations in the survey report or that it violated any regulations. The agency is submitting this POC in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</p>	
N 0470 Bldg. 00	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation and interview, the Registered Nurse failed to ensure infection control was maintained by ensuring gloves were worn during medication administration and hand hygiene performed between glove changes for 1 of 3 observations conducted. (Patient #3)</p> <p>Findings include:</p>	N 0470	<p>1. Clinical Manager reviewed Infection control with the Clinical Supervisor team 5/18/21 and 6/21/21 Employee C was re educated on proper infection control and handwashing on 5/11/21.</p> <p>In-home infection control measures will be evaluated and reinforced by the RN during</p>	09/30/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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PRINTED: 08/25/2021

FORM APPROVED
OMB NO. 0938-039

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N 0486 Bldg. 00	<p>During a home visit on 5/11/21 at 4:00 PM, Employee C was observed providing oral suctioning to patient #3. Once the suctioning was completed, Employee C was observed to remove the right glove and don a new glove without hand sanitizing or washing. After Employee C applied lip balm, the employee removed her gloves and took the patient into the kitchen. No hand hygiene was completed.</p> <p>Employee C then proceeded to obtain the patient's temperature, documented, then blood pressure, removed oxygen saturation machine from a bag in the back of the patient's chair, auscultated the patient's lungs and abdomen, checked upper and lower extremity pulses, removed the patient's jacket, opened a drawer and retrieved 3 syringes, went to the kitchen counter and connected tubing to one of the 3 syringes, and don new gloves and attached the tube with the syringe without hand hygiene. After placement was verified, Employee C removed her gloves and went inside a kitchen drawer and retrieved a spoon, stirred the patient's medications, added tube feeding into the feeding bag alone with the patient's medications without hand hygiene. The employee was observed to remove her gloves and proceeded to connect the patient's feeding tube to the patient without donning new gloves.</p> <p>During the observation, the employee was queried if she should have completed hand hygiene after each glove removal, Employee C stated "Yes."</p> <p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p>		N 0486	<p>in-home supervisory visits (ongoing). Supervisory visit documentation to be reviewed quarterly to insure 100% compliance.</p> <p>3. To ensure this deficiency does not recur, education will be provided to all new hires during initial competency as evidenced by the documentation on the skilled nurse initial and annual competency form. In addition, the Administrator/Clinical Manager or Clinical Designee will complete quarterly self-audit review of 10 or 10% (whichever is greater) of active skilled nursing personnel files to ensure competency forms, including infection control are documented per policy.</p>
			1. Administrator/Clinical	COMPLETION DATE 08/25/2021

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	<p>Based on record review and interview, the agency failed to ensure they coordinated services with an outside agency for 1 of 1 record reviewed of a patient receiving home health aide services from a personal service agency. (Patient #2)</p> <p>Findings include:</p> <p>During the entrance conference on 5/10/21, the agency was asked to provide a list of patients whom they share services with. At 2:00 PM, the agency provided a list, which revealed patient #2 received services from an outside agency.</p> <p>The electronic clinical record for patient #2 was reviewed on 5/11/2021, in which coordination notes revealed the patient was received services from a Personal Service Agency.</p> <p>During an interview on 5/12/2021 at 4:30 PM, the Administrator and Alternate Administrator were queried if they had any coordination documentation with the personal service agency, in which both answered "No".</p>		<p>manager provided education to all clinical supervisors on policy "Care Coordination/Case Conference" regarding the requirement interdisciplinary coordination of care to ensure thorough communication at least once every certification period and upon notification of change in patient condition during a clinical team meeting 5/18/21 and 6/21/21 as evidenced by team meeting agenda.</p> <p>2. The Administrator/Clinical Manager or clinical designee will audit 100% of client census to ensure care coordination is completed for all interdisciplinary agencies providing care for a client and documented the electronic medical record at least once every certification period and upon notification of change in patient condition. This audit will be completed within 30 days.</p> <p>3. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Administrator/Clinical Manager or Clinical Designee on a quarterly basis to ensure documentation reflects care coordination is completed for all interdisciplinary agencies providing care for a client at least once every certification period.</p>	

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N 0520 Bldg. 00	<p>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.</p> <p>Based on record review and interview, the agency failed to ensure they had adequate staff available to meet patient health needs for 4 Patients #1, 2, 3, 4) of 5 active records reviewed and 2 (Patient #7, 8) of 2 closed records reviewed.</p> <p>Findings include:</p> <p>1. The clinical record of patient #2 was reviewed on 5/11/21. The clinical record contained a plan of care for the certification period of 3/25/21 to 5/28/21, with orders for skilled nursing to provide respite services 40 hours/ week and skilled nursing services 5 - 7 days/ week, 26 - 40 hours per week with alternating every other Saturday with every other Sunday. The patient diagnoses included, but not limited to Amyotrophic lateral sclerosis (ALS/ known as Lou Gehrig's disease which is a disease that weakens the muscles and impacts physical function); Tracheostomy (tube inserted in the trachea/ throat that opens an airway for breathing) with Vent dependence (machine that assists patients to breath mechanically), Percutaneous endoscopic gastrostomy tube (PEG - flexible feeding tube placed through the abdominal wall and into the stomach which allows nutrition, fluids, and medications to be put directly into the stomach), Chronic Kidney Disease - Stage I, and Chronic Respiratory Failure. Skilled nursing services to be provided included but not limited to Tracheostomy Care, Ventilator Management,</p>	N 0520	<p>1. Administrator/Clinical Manager will educate 100% of internal office staff on the agency's current Acceptance and Admission Policy during office QI meeting 5/26/21 and an office process will be followed in order to ensure that all patients accepted for admission are provided services based on individualized plan of care effective 8/25/21.</p> <p>a. Office Process: Administrator or designee will review 100% of referrals and accept only patient/clients for service based on the adequacy and suitability of the personnel, resources to provide required services, and the reasonable expectation that the patient/client's medical, nursing, rehabilitative, and/or social needs can be adequately met in the patient/client's place of residence. Daily team meetings (Red Zone) will occur at the beginning and end of every day to discuss open shifts. Real time notification and follow up will be made to families and documented in a patient logging. The client coordinator and recruiter will schedule patient</p>	08/25/2021

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	<p>Tube Feedings and site care, personal care, medication administration, suctioning, water flushes.</p> <p>Review of the patient's hard chart, the last skilled nursing visit note to indicate the last time services were provided was on 3/23/21.</p> <p>Review of the patient's electronic medical record (EMR), revealed a calendar that had dark gray color from 3/24/21 to present. Next to the calendar, is a key which revealed that dark gray means visits were canceled.</p> <p>Review of an agency document titled "Clinical Notes Report" dated 3/25/2021 revealed that a comprehensive recertification assessment had been completed on 3/19/21. The patient had to have their trach changed in the hospital and also had surgery to remove excess granulation tissue from the trach stoma. The note went on to reveal the patient had bloody drainage from tracheal secretions, was given an antibiotic 2 times/ day x 10 days due to the client having a fever of unknown origin, and Carcumin and MitQ was to be added to the patient's tube feedings daily.</p> <p>The clinical notes report failed to evidence any communication with the patient and/ or caregiver of the agency's inability to staff and recommending to transfer the patient to another provider who may be able to meet the patient's needs.</p> <p>The finding were reviewed with the Administrator on 5/11/21 at 2:50 PM. The Administrator stated Employee F, LPN, had came to them and voiced some concerns and wanted to be removed from the patient's care immediately. The Administrator stated they have had difficulty with getting</p>		<p>specific orientations for back up caregivers in the event of a callout or scheduled vacation.</p> <p>Administrator /Clinical manager will review Missed Opportunities and address discrepancies during the Quarterly QAPI team committee meetings.</p> <p>3. To ensure this deficiency does not recur, 10 clinical records or 10% of all clinical records, whichever is greater, will be audited quarterly to ensure that the agency has adequately met Patient staffing needs and ensure compliance with missed shift Policy.</p>	

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	<p>people to apply for work. They had offered referral and sign on bonuses to no avail, however, they recently have two candidates hired and waiting on skills competency and training with the patient.</p> <p>During an interview with Individual K, caregiver of patient #2, on 5/13/21 at 11:42 AM, the Individual verified that services stopped in late March, and no one from the agency has offered to assist them on finding an alternative agency.</p> <p>2. The clinical record of patient #3 was reviewed on 5/11/21. The clinical record contained a plan of care for the certification period of 3/11/21 to 5/9/21, with orders for skilled nursing services 3-5 days per week, 18-30 hours per week for 60 days, plus an additional 780 hours of respite skilled nursing services via waiver to be used at the family/ client's discretion from 3/1/21 to 2/28/22.</p> <p>A review of the patients EMR (electronic medical record) calendar revealed the agency was unable to staff on 3/16, 3/23, 4/10, 4/11, and 4/27/21.</p> <p>During an interview with (active patient) patient #3's parent on 5/13/21 at 11:26 AM, the parent indicated there has always been a problem with staffing and that it has been challenging.</p> <p>3. The clinical record of patient #1 was reviewed on 5/11/21. The clinical record contained a plan of care for the certification period of 4/25/21 to 6/23/21, with orders for skilled nursing services 31-52 hours per week, 2-4 days per week for 60 days, plus 720 hours of respite nursing via waiver from 12/1/20 to 11/20/21 to be used at the client/ family dispositions. The 60 summary on this plan of care stated " ... There were a total of 12 missed shifts. All 12 shifts were canceled due to no</p>			

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	<p>qualified caregiver available. ... "</p> <p>4. The clinical record of patient #4, revealed a plan of care for the certification period of 3/21/21 to 5/19/21, with orders for skilled nursing 1-2 days per week, 11-18 hours per week for 60 days, plus and additional 1305 hours of respite skilled nursing services via waiver, to be used at the family/ client's discretion from 2/1/2021 through 1/21/2022. The 60 summary on this plan of care stated " ... There was 1 missed shift over the last certification period due to no qualified caregiver available...."</p> <p>5. Review of the clinical record of patient #7, revealed a plan of care for the certification period of 12/4/15 to 2/1/16, with orders for home health aide services 3 to 5 days per week, 27 to 45 hours per week and eligible for 80 hours per month of home health aide waiver services. The home health aide was to provide personal care, assist with mobility, toileting, housekeeping, and may accompany to school and medical appointments during ATTC hours only.</p> <p>On 12/23/2015, Former Employee L notified the patient #7's parent for verification of needs for the month of January and February 2016, in which the document indicated the parent "confirmed that she did not need any days with NO service ... her schedule is Mon, Th, F 6A - 6P, Tu 6A - 7P, W 7A - 6P.</p> <p>A grievance documentation report dated 1/27/16, the parent notified Former Employee L that she was having continued communication concerns from the scheduling team and that their inability to fill the full schedule was causing issues at home and school. Former Employee L asked for clarification and updated schedules were send for</p>			

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	<p>services for January and February by a recruiter.</p> <p>Review of agency documents titled "Missed Visit/Shift Notification" revealed the following dates and times of missed visits by the agency due to "lack of aides available to work that day":</p> <p>12/21/15 from 6A to 6P 12/29/15 and 12/30/15 from 6A to 6P 1/4/16 and 1/6/16 from 6A to 6P 1/22/16 from 6A to 6P 1/29/16 from 6A to 6P</p> <p>Review of a "Client/ Facility Logging Report" dated 1/29/16, revealed that the patient's was seen at her physician's office follow a fall at the school on 1/27/16. Another entry timed 8:20 AM indicated the patient fell at school during a transfer in the bathroom. Maxim staff was not with her. Large area of purple bruising, swelling and hematoma in right rib/ flank area with client currently having pain, and pain in right hand and right hip, but no redness, bruising or swelling in said areas.</p> <p>Review of a "Client/ Facility Logging Report" dated 2/11/16, revealed the school corporation notified the agency that all transfers for the patient at school is to be made 2 people transfer assist.</p> <p>Review of a "Client/ Facility Logging Report" dated 2/15/16, revealed an order from the patient's physician that the patient is to have a 2 person transfer at school utilizing school trained staff to assist, per school request.</p> <p>Review of a "Client/ Facility Logging Report" dated 3/24/16, the agency received notice from the parent that they were no longer needing the</p>			

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	<p>agency's services effective 3/30/16. The note went on to indicate that "Maxim has been less than sufficient in providing services for several months. We need reliable services."</p> <p>During an interview with the parent on 5/12/21 at 4:12 PM, the parent stated they would have to miss work when the agency couldn't staff. The parent indicated even when the agency was notified of vacations in advance, they wouldn't notify the parent timely to for them to schedule time off versus having to call off. As for school, the parent indicated the school needed to know who would be attending with the patient in advance and required a background check. If the agency didn't provide this, the aide would not be able to attend school with the patient. The parent indicated the aide duties would include helping the patient in/ out of the doors, assist with books, lunch, bathroom, etc. The parent indicated the HHA would leave the premises for 1/2 hr to 1 hr at a time. The parent indicated the patient had to use special equipment and if there was a fire or drill, there would be no one to assist her. The parent said she had spoke to several people about her concerns but there was no call back for resolutions.</p> <p>6. A review of the coordination notes between the guardian of patient #8 and the agency, revealed there was an issue with the agency's staff administering medications at the wrong time and missing visits.</p> <p>On 1/11/17, an entry was made by the agency indicating that the Administrator and Former Employee L had spoken with the guardian on any updates for identifying a back up caregiver to provide client's care in the event of a missed visit. The guardian requested that the case manager or</p>			

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	<p>the clinical supervisor provide back-up to the nurses, and documentation revealed this request was denied.</p> <p>On 1/23/17, an entry made by the agency, notifying the patient's physician that the patient's 12 PM medication doses were missed due to not having a nurse available.</p> <p>On 2/1/17, an entry made by the agency, notifying the physician of the agency's intent to discharge the patient because the guardian was not willing to provide care when the agency is not able to staff.</p> <p>On 2/2/17, an entry made by the agency revealed that a SN visit to administrator the patient's AM medication was missed.</p> <p>During an interview with the guardian on 5/12/21 at 4:27 PM, the guardian stated when she would call the agency, she would get referred from one person to another, left message, then ended up showing up at the office. The guardian said staff was an issue and medications, like insulin were getting missed. The guardian asked for the agency's policy and procedure for staffing and call offs but the agency would not provide her with one. The guardian stated there was no resolution with her complaints so she decided to leave the agency.</p> <p>7. During an entrance conference interview on 3/10/21 at 11:33 AM, when queried if there were any services the agency had problems staffing, the Administrator stated "All of them." The Administrator went on to state that they have offered incentives, bonuses/ bonus programs without success and has offered patient/ caregivers to help them find another agency to</p>			

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N 0522 Bldg. 00	<p>meet their needs if they are unable to staff.</p> <p>8. During an interview with the Administrator and Alternate Administrator on 5/13/21 at 4:55 PM. When queried how the agency managed staffing when there was a call-in or planned vacation, the Administrator stated it was an issue and could be difficult to staff if no one was already on the schedule. The Administrator went on to state that the recruiters/ schedulers try to get someone for a meet/ greet as well as to shadow for open shifts, and they encouraged family to have more than 1 staff member in the home. The Administrator stated they would try to tell families what they know, when they know, in regards to an advance notice.</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on record review and interview, the agency failed to ensure services were provided as ordered on the plan of care for 4 Patients #1, 2, 3, 4) of 5 active records reviewed and 2 (Patient #7, 8) of 2 closed records reviewed.</p> <p>Findings include:</p> <p>1. The clinical record of patient #2 was reviewed on 5/11/21. The clinical record contained a plan of care for the certification period of 3/25/21 to 5/28/21, with orders for skilled nursing to provide respite services 40 hours/ week and skilled nursing services 5 - 7 days/ week, 26 - 40 hours per week with alternating every other Saturday</p>	N 0522	<p>1. Administrator/Clinical Manager educated 100% of the office team during team QI meeting on 6/21/21 and 6/23/21, on agency's Plan of Care policy for the patient's plan of care to be developed, documented, and individualized to the patient including: All pertinent diagnoses, the patient's mental, psychosocial and cognitive status, types of services, supplies and equipment, frequency and duration of visits to be made including the specific number of hours provided per day, prognosis, rehabilitation potential,</p>	08/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157684	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021
NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP COD 6612 E 75TH ST SUITES 400 INDIANAPOLIS, IN 46250	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
	<p>with every other Sunday. The patient diagnoses included, but not limited to Amyotrophic lateral sclerosis (ALS/ known as Lou Gehrig's disease which is a disease that weakens the muscles and impacts physical function); Tracheostomy (tube inserted in the trachea/ throat that opens an airway for breathing) with Vent dependence (machine that assists patients to breath mechanically), Percutaneous endoscopic gastrostomy tube (PEG - flexible feeding tube placed through the abdominal wall and into the stomach which allows nutrition, fluids, and medications to be put directly into the stomach), Chronic Kidney Disease - Stage I, and Chronic Respiratory Failure. Skilled nursing services to be provided included but not limited to Tracheostomy Care, Ventilator Management, Tube Feedings and site care, personal care, medication administration, suctioning, water flushes.</p> <p>Review of the patient's hard chart, the last skilled nursing visit note to indicate the last time services were provided was on 3/23/21.</p> <p>Review of the patient's electronic medical record (EMR), revealed a calendar that had dark gray color from 3/24/21 to present. Next to the calendar, is a key which revealed that dark gray means visits were canceled.</p> <p>Review of an agency document titled "Clinical Notes Report" dated 3/25/2021 revealed that a comprehensive recertification assessment had been completed on 3/19/21. The patient had to have their trach changed in the hospital and also had surgery to remove excess granulation tissue from the trach stoma. The note went on to reveal the patient had bloody drainage from tracheal secretions, was given an antibiotic 2 times/ day x</p>			<p>functional limitations, activities permitted, nutritional, medications and treatments requirements including frequency between doses and duration, safety measures to protect against injury, patient's risk for emergency, advance directives, and discharge plan.</p> <p>a. Administrator/Clinical Manager or Clinical designee will audit monthly 100% of active patients Plans of Care during the recertification process to ensure were developed and documented individualized to the patient and frequency of services are provided as ordered.</p> <p>2. 100% of office staff educated on agencies missed shift documentation policy and process during weekly meeting on 6/23/21 including</p> <p>a. Review of on call log daily to ensure that all missed shifts are documented and supportive loggings are be entered. 100% of all competent and qualified caregivers are to be notified of all open shifts. As appropriate administrator/clinical manager or designee will notify case manager of missed services and reach out to other agencies or provide community resources as needed.</p> <p>b. 100% of client schedules and on call loggings will be reviewed weekly to ensure supportive documentation of client missed shifts are entered in client</p>

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157684	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021
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	<p>10 days due to the client having a fever of unknown origin, and Curcumin and MitQ was to be added to the patient's tube feedings daily.</p> <p>The clinical notes report failed to evidence any communication with the patient and/ or caregiver of the agency's inability to staff and recommending to transfer the patient to another provider who may be able to meet the patient's needs.</p> <p>The finding were reviewed with the Administrator on 5/11/21 at 2:50 PM. The Administrator stated Employee F, LPN, had came to them and voiced some concerns and wanted to be removed from the patient's care immediately. The Administrator stated they have had difficulty with getting people to apply for work. They had offered referral and sign on bonuses to no available, however, they recently have two candidates hired and waiting on skills competency and training with the patient.</p> <p>During an interview with Individual K, caregiver of patient #2, on 5/13/21 at 11:42 AM, the Individual verified that services stopped in late March, and no one from the agency has offered to assist them on finding an alternative agency.</p> <p>2. The clinical record of patient #3 was reviewed on 5/11/21. The clinical record contained a plan of care for the certification period of 3/11/21 to 5/9/21, with orders for skilled nursing services 3-5 days per week, 18-30 hours per week for 60 days, plus an additional 780 hours of respite skilled nursing services via waiver to be used at the family/ client's discretion from 3/1/21 to 2/28/22.</p> <p>A review of the patients EMR (electronic medical record) calendar revealed the agency was unable</p>		<p>loggings.</p> <p>c. The Administrator/Clinical Manager is responsible for monitoring these corrective actions to ensure that this alleged deficiency is corrected and does not recur.</p> <p>d. A Float Pool program will be implemented in order to provide flexible staffing to ensure client staffing needs will be met.</p> <p>e. To ensure this deficiency does not recur, 10 clinical records or 10% of all clinical records, whichever is greater, will be audited quarterly to ensure that patients receive services per physician orders.</p> <p>3. To ensure this deficiency does not recur, 10 clinical records or 10% of all clinical records, whichever is greater, will be audited quarterly to ensure that direct caregivers, to include home health aides, LPNs and RNs, are following the physician orders including frequency and duration and duration of services provided.</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157684	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021
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	<p>to staff on 3/16, 3/23, 4/10, 4/11, and 4/27/21.</p> <p>During an interview with (active patient) patient #3's parent on 5/13/21 at 11:26 AM, the parent indicated there has always been a problem with staffing and that it has been challenging.</p> <p>3. The clinical record of patient #1 was reviewed on 5/11/21. The clinical record contained a plan of care for the certification period of 4/25/21 to 6/23/21, with orders for skilled nursing services 31-52 hours per week, 2-4 days per week for 60 days, plus 720 hours of respite nursing via waiver from 12/1/20 to 11/20/21 to be used at the client/family discretion. The 60 summary on this plan of care stated " ... There were a total of 12 missed shifts. All 12 shifts were canceled due to no qualified caregiver available. ... "</p> <p>4. The clinical record of patient #4, revealed a plan of care for the certification period of 3/21/21 to 5/19/21, with orders for skilled nursing 1-2 days per week, 11-18 hours per week for 60 days, plus and additional 1305 hours of respite skilled nursing services via waiver, to be used at the family/ client's discretion from 2/1/2021 through 1/21/2022. The 60 summary on this plan of care stated " ... There was 1 missed shift over the last certification period due to no qualified caregiver available...."</p> <p>5. Review of the clinical record of patient #7, revealed a plan of care for the certification period of 12/4/15 to 2/1/16, with orders for home health aide services 3 to 5 days per week, 27 to 45 hours per week and eligible for 80 hours per month of home health aide waiver services. The home health aide was to provide personal care, assist with mobility, toileting, housekeeping, and may accompany to school and medical appointments</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157684	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021
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	<p>during ATTC hours only.</p> <p>On 12/23/2015, Former Employee L notified the patient #7's parent for verification of needs for the month of January and February 2016, in which the document indicated the parent "confirmed that she did not need any days with NO service ... her schedule is Mon, Th, F 6A - 6P, Tu 6A - 7P, W 7A - 6P.</p> <p>A grievance documentation report dated 1/27/16, the parent notified Former Employee L that she was having continued communication concerns from the scheduling team and that their inability to fill the full schedule was causing issues at home and school. Former Employee L asked for clarification and updated schedules were send for services for January and February by a recruiter.</p> <p>Review of agency documents titled "Missed Visit/ Shift Notification" revealed the following dates and times of missed visits by the agency due to "lack of aides available to work that day":</p> <p>12/21/15 from 6A to 6P 12/29/15 and 12/30/15 from 6A to 6P 1/4/16 and 1/6/16 from 6A to 6P 1/22/16 from 6A to 6P 1/29/16 from 6A to 6P</p> <p>Review of a "Client/ Facility Logging Report" dated 1/29/16, revealed that the patient's was seen at her physician's office follow a fall at the school on 1/27/16. Another entry timed 8:20 AM indicated the patient fell at school during a transfer in the bathroom. Maxim staff was not with her. Large area of purple bruising, swelling and hematoma in right rib/ flank area with client currently having pain, and pain in right hand and right hip, but no redness, bruising or swelling in</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157684	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021
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	<p>said areas.</p> <p>Review of a "Client/ Facility Logging Report" dated 2/11/16, revealed the school corporation notified the agency that all transfers for the patient at school is to be made 2 people transfer assist.</p> <p>Review of a "Client/ Facility Logging Report" dated 2/15/16, revealed an order from the patient's physician that the patient is to have a 2 person transfer at school utilizing school trained staff to assist, per school request.</p> <p>Review of a "Client/ Facility Logging Report" dated 3/24/16, the agency received notice from the parent that they were no longer needing the agency's services effective 3/30/16. The note went on to indicate that "Maxim has been less than sufficient in providing services for several months. We need reliable services."</p> <p>During an interview with the parent on 5/12/21 at 4:12 PM, the parent stated they would have to miss work when the agency couldn't staff. The parent indicated even when the agency was notified of vacations in advance, they wouldn't notify the parent timely to for them to schedule time off versus having to call off. As for school, the parent indicated the school needed to know who would be attending with the patient in advance and required a background check. If the agency didn't provide this, the aide would not be able to attend school with the patient. The parent indicated the aide duties would include helping the patient in/ out of the doors, assist with books, lunch, bathroom, etc. The parent indicated the HHA would leave the premises for 1/2 hr to 1 hr at a time. The parent indicated the patient had to use special equipment and if there was a fire or</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157684	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021
NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP COD 6612 E 75TH ST SUITES 400 INDIANAPOLIS, IN 46250		
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	<p>drill, there would be no one to assist her. The parent said she had spoke to several people about her concerns but there was no call back for resolutions.</p> <p>6. A review of the coordination notes between the guardian of patient #8 and the agency, revealed there was an issue with the agency's staff administering medications at the wrong time and missing visits.</p> <p>On 1/11/17, an entry was made by the agency indicating that the Administrator and Former Employee L had spoken with the guardian on any updates for identifying a back up caregiver to provide client's care in the event of a missed visit. The guardian requested that the case manager or the clinical supervisor provide back-up to the nurses, and documentation revealed this request was denied.</p> <p>On 1/23/17, an entry made by the agency, notifying the patient's physician that the patient's 12 PM medication doses were missed due to not having a nurse available.</p> <p>On 2/1/17, an entry made by the agency, notifying the physician of the agency's intent to discharge the patient because the guardian was not willing to provide care when the agency is not able to staff.</p> <p>On 2/2/17, an entry made by the agency revealed that a SN visit to administrator the patient's AM medication was missed.</p> <p>During an interview with the guardian on 5/12/21 at 4:27 PM, the guardian stated when she would call the agency, she would get referred from one person to another, left message, then ended up</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157684	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021
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N 0524 Bldg. 00	<p>showing up at the office. The guardian said staff was an issue and medications, like insulin were getting missed. The guardian asked for the agency's policy and procedure for staffing and call offs but the agency would not provide her with one. The guardian stated there was no resolution with her complaints so she decided to leave the agency.</p> <p>7. During an entrance conference interview on 3/10/21 at 11:33 AM, when queried if there were any services the agency had problems staffing, the Administrator stated "All of them." The Administrator went on to state that they have offered incentives, bonuses/ bonus programs without success and has offered patient/ caregivers to help them find another agency to meet their needs if they are unable to staff.</p> <p>8. During an interview with the Administrator and Alternate Administrator on 5/13/21 at 4:55 PM. When queried how the agency manages staffing when there is a call-in or planned vacation, the Administrator stated it is an issue and can be difficult to staff if no one is already on the schedule. The Administrator went on to state that the recruiters/ schedulers try to get someone for a meet/ greet as well as to shadow for open shifts, and they encourage family to have more than 1 staff member in the home. The Administrator stated they would try to tell families what they know, when they know, in regards to an advance notice.</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff.</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157684	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021
NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP COD 6612 E 75TH ST SUITES 400 INDIANAPOLIS, IN 46250		
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	<p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on record review and interview, the agency failed to ensure patient duration and frequency were not in large ranges and specific to the patients needs and specific to the certification dates for 5 (Patients #1, 2, 3, 4, 5) out of 5 active records reviewed, failed to ensure the medication profile included a location to apply ointment for 1 (Patient #3) out of 4 active records reviewed of patients receiving treatment with ointments/creams, and failed to ensure the plan of care include information in relation to shared agencies (type of services and frequency of services) for 1 (Patient #2) out of 1 record reviewed of a patient receiving outside services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The clinical record of patient #1 was reviewed 	N 0524	<p>1. Administrator/Clinical Manager educated 100% of Clinical Supervisors on policy "Home Health Certification and Plan of Care" on the requirement the Plan of Care will be individualized to include, but not limited to, services authorized to be provided by direct care staff. Additionally, the Administrator/Clinical Manager educated all internal staff, including Clinical Supervisors, Recruiters and Field Support, on policy "Patient/Client Scheduling"</p> <p>a. This education was provided to all internal staff during a team meeting on 6/23/21 as evidenced by the meeting agenda</p>	09/14/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157684	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021
NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP COD 6612 E 75TH ST SUITES 400 INDIANAPOLIS, IN 46250		
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	<p>on 5/10/21. The record contained a plan of care for the certification period of 4/25/21 to 6/25/21, with orders for skilled nursing 31-52 hours per week, 2-4 days / week for 60 days and 720 hours of skilled nursing respite care via waiver to be used at the family/ client's discretion from 12/1/20 to 11/30/21.</p> <p>Review of the skilled nursing visit notes from 3/15 to present, the patient has been receiving skilled nursing services Monday through Thursday. On Mondays, the nursing hours provided have been 6:00 AM to 6:45 to 7:00 PM. On Tuesday and Wednesdays, 4 out of 6 weeks, nursing hours provided have been from 6:00 AM to 3:00 PM, and the other 2 weeks, the nurse provided services to 2:30 PM and 5:00 PM. On Thursdays, 5 out of 7 weeks, the nursing hours provided were 10:00 AM to 4:45 PM and the other 2 weeks, nursing provided services 8:11 AM to 5:00 PM and 9:15 AM to 4:35 PM.</p> <p>2. During the entrance conference on 5/10/21, the agency was asked to provide a list of patients whom they share services with. At 2:00 PM, the agency provided a list, which revealed patient #2 receiving services from an outside agency.</p> <p>The electronic clinical record for patient #2 was reviewed on 5/11/2021, in which the coordination notes revealed the patient was receiving services from a Personal Service Agency. The clinical record contained a plan of care for the certification period of 3/25/21 to 5/23/21, and failed to evidence the type of services and their frequency of services that the patient was receiving services from an outside personal service agency.</p> <p>Review of the electronic medical record calendar for the certification period of 3/25/21 to 5/23/21,</p>		<p>and signed attendance.</p> <p>2. Administrator/Clinical Manager or designee will audit 100% of active client's frequency and duration to ensure frequency and durations are individualized to patient needs, the frequency and durations include the number of hours per day, and are being met per current schedule. Audit will be completed 9/14/21. Any discrepancy /missed shifts will be sent to the corresponding physician</p> <p>a. Ongoing, Missed shift notification sent to physician for notification of deviation from POC weekly or monthly in accordance with patient service authorization.</p> <p>3. Ongoing, Office Leadership or Designee will be responsible for reviewing the client's 485 during the recertification process for accuracy in frequency and duration to ensure documentation accurately reflects the services provided per the individual plan of care including the numbers of hours per day.</p> <p>4. To ensure this deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Administrator/Clinical Manager or Clinical Designee on a quarterly basis to ensure documentation accurately reflects that the responsible party was informed of changes in frequency.</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157684	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021
NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP COD 6612 E 75TH ST SUITES 400 INDIANAPOLIS, IN 46250		
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	<p>revealed visits were blocked to specific hours of 9:00 AM to 2:00 PM Monday through Friday and every other Saturday/ Sunday were blocked for 12:00 PM to 10:00 PM.</p> <p>The plan of care frequency and duration failed to be specific to the patient needs to include the hours per day versus hours per week and specific to the certification period.</p> <p>During an interview on 5/12/2021 at 4:30 PM, the Administrator and Alternate Administrator was queried if they had any coordination documentation with the personal service agency, in which both answered "No".</p> <p>3. The clinical record of patient #3 was reviewed on 5/12/21. The clinical record contained a plan of care for the certification period of 3/11/21 to 5/9/21, with orders for skilled nursing 3-5 days per week, 18-30 hours per week for 60 days with an additional 780 hours of respite skilled nursing services via waiver to be used at the family/ client's discretion from 3/1/21 to 2/28/22.</p> <p>Review of the clinical record revealed the patient was receiving skilled nursing services after the patients gets off from school (approximately 4:00 PM) until 7-8 PM in the evening. Prior to the patient returning to school, skilled nursing was providing services throughout the day but the hours varied.</p> <p>The plan of care frequency and duration failed to be specific to the patient needs to include the hours per day versus hours per week and specific to the certification period.</p> <p>4. The clinical record of patient #4 was reviewed on 5/12/21. The clinical record contained a plan of</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157684	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021
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	<p>care for the certification period of 3/21/21 to 5/19/21, with orders for skilled nursing services 1 - 2 days per week, 11 - 18 hours per week for 60 days, and 1305 hours of Respite skilled nursing services via waiver to be used at the family's discretion from 2/1/2021 to 1/31/2022. The medication section revealed an order for bacitracin zinc 500 unit/gram topical ointment, a thin layer to be applied as needed for irritation.</p> <p>Review of the skilled nursing visit notes revealed the patient has been receiving skilled nursing services every Thursday and Friday, as early as 7:23 AM to as late as 4:24 PM. The patient has also been receiving skilled nursing respite services Sunday to Wednesday. The Sunday hours have been from 10 to 4 to 4:30 PM and the weekday hours have been starting between 7:15 to 7:30 AM to as late as 4:30 PM.</p> <p>The plan of care frequency and duration failed to be specific to the patient needs, to include the hours per day versus hours per week/ year, specific to the certification period, and the bacitracin ointment directions failed to evidence a location of the skin irritation.</p> <p>5. The clinical record of patient #5 was reviewed on 5/12/21. The clinical record contained a plan of care for the certification period of 4/7/21 to 6/5/21 with orders for home health aide services 3-5 days per week, 24-40 ours per week for 60 days and 46 hours per month for attendant care services via waiver, to be used at the family's discretion for 60 days.</p> <p>Review of the home health aide visit notes revealed the patient has been home health aide receiving services Monday through Friday from 7:00 AM to 3:00 PM and attendant care services</p>			

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

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N 0541 Bldg. 00	<p>from 3:00 PM to 4:00 PM.</p> <p>The plan of care frequency and duration failed to be specific to the patient needs, to include the hours per day versus hours per week/ year, specific to the certification period.</p> <p>6. During an interview on 5/11/21 at 10:55 AM, when queried on the frequency and duration on the plan of care, the Administrator stated she was aware that the frequency should be specific in relation to hours per day. When asked how the staff know how long they are to be at a patient's home, the Administrator stated they take the maximum hours/week and divide by the maximum days/ week and that would determine the hours per day.</p> <p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.</p> <p>Based on record review and interview, the agency failed to ensure the Registered Nurse completed an in-home recertification assessment for 2 out of 4 active records reviewed of patients recertified for continuing skilled services for an additional 60 days. (Patients # 1, 2)</p> <p>Findings include:</p> <p>The clinical record of patient #1 was reviewed and contained a comprehensive assessment dated 4/23/21 per RN signature. Review of the 60-day</p>	N 0541	<p>1. The Administrator/Clinical Manager educated 100% of clinical supervisors on the requirement for admission and recertification assessments must be completed in person every 60 days and not via telehealth per Indiana and Federal Waiver on 5/15/21.</p> <p>a. Administrator/Clinical Manager will review 100% of active patient recertification's weekly to ensure recertification and</p>	05/14/2021

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

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N 0608 Bldg. 00	<p>summary on page 29 of 30, revealed the patient "was seen on 4/22/21 for comprehensive recertification assessment done via telehealth video visit with client and SIN in client home.... VS [vital signs] obtained and assessment performed by nurse on duty [Name of Employee I, LPN] " This assessment failed to be completed in person by a Registered Nurse.</p> <p>The clinical record of patient #2 was reviewed and contained a comprehensive assessment dated 3/19/2021 per RN signature. Review of the 60-day summary on page 27 of 28, revealed the patient "was seen in home on 3/19/21 for comprehensive recertification assessment with SN [Name of Employee F] LPN present for the visit. This assessment failed to be completed in person by a Registered Nurse.</p> <p>The findings were reviewed with the Administrator and the Alternate Administrator on 5/11/21 at 10:55 AM. The Administrator and Alternate Administrator stated they were told by FSSA that it was ok for them to conduct virtual comprehensive assessments and the FSSA obtained this verification from the assistant commissioner from IDOH. The Indiana, as well as the Federal, waiver was reviewed with the Administrator and the Alternate Administrator during this time and reiterated only the initial assessment, to determine if the patient is appropriate for services, can be made virtually, otherwise, all comprehensive assessments (admission and recertification) must be done in person by a Registered Nurse.</p> <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in</p>		<p>admission assessments are completed in person every 60 days.</p> <p>2. To ensure this deficiency does not recur, 10 or 10%, whichever is greater, of the active patient visits will be reviewed by the Administrator/Clinical Manager or Clinical Designee on a quarterly basis to ensure the patient recertification visits are completed in person.</p>	

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	<p>accordance with accepted professional standards shall be maintained for every patient as follows:</p> <ol style="list-style-type: none"> (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. <p>Based on record review and interview, the agency failed to ensure the home health aide entered their tasks appropriately during attendant care hours for 1 out of 1 record reviewed of a patient receiving home health aide and attendant care services. (Patient #5)</p> <p>Findings include:</p> <p>The clinical record of patient #5 was reviewed on 5/12/21. The clinical record contained a plan of care for the certification period of 4/7/21 to 6/5/21 with orders for home health aide services 3-5 days per week, 24-40 ours per week for 60 days and 46 hours per month for attendant care services via waiver, to be used at the family's discretion for 60 days.</p> <p>Review of the home health aide visit notes revealed the patient has been home health aide receiving services Monday through Friday from</p>	N 0608	<p>Electronic Medical record QA weekly and providing education. Documented in employee loggings Clinical staff reeducated 6/2/21.</p> <ol style="list-style-type: none"> 1. The Administrator/Clinical Manager will re-educate all Clinical Supervisors, including Employee E, on company policy "Patient/Client Record: Content and Requirements" to ensure treatments are provided and documented per the Home Health Aide Plan of Care. 2. Employee E was reeducated by Clinical Supervisor on 6/8/21 and 6/14/21 as evidence by employee logging. Employee resigned as of 6/25/21 3. 100% of unskilled staff were educated on Patient Record content and documentation during in home competencies by 5/30/21 	06/25/2021

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	<p>7:00 AM to 3:00 PM and attendant care services from 3:00 PM to 4:00 PM.</p> <p>Review of the home health aide care plan revealed the aide was to assist with ambulation, transfer, assist in/ out of bed, reposition, passive and active range of motion, assist with toileting, incontinence/ peri-care/ brief daily, document the last bowel movement, hair care/ shampoo, mouth care, skin care, nail care, assist with dressing daily, prepare meal, serve meal, encourage fluids daily, laundry, clean bathroom, make/ change bed, clean kitchen and bedroom, vacuum/ sweep, and may take patient outside daily. The care plan also revealed that the aide may run essential errands with client during attendant care hours only, may accompany to medical appointments, medication reminders and client to wear TED hose as tolerated.</p> <p>A review of the electronic home health aide visit notes and the attendant care visit notes, the home health documented that the same services were provided for both home health aide and attendant care hours, such as bathing, shampoo, mouth care, and nail care.</p> <p>During an interview on 3/13/21 at 8:23 AM, when queried when the home health performed the patient bath, Employee E, home health aide, stated that the patient receives their bath every morning.</p> <p>The home health aide documentation was reviewed with the Administrator and Alternate Administrator on 5/13/21 at approximately 10:00 AM. During this time, the Administrator was queried if it was appropriate for the home health aide to document completed tasks under attendant care that was completed under the home health aide PA hours, in which the Administrator</p>			<p>as evidenced by signed annual competency.</p> <p>4. 100% review of unskilled documentation will be performed weekly for 30 days to ensure that all orders for treatment, including assist with ambulation, transfer, assist in/ out of bed, reposition, passive and active range of motion, assist with toileting, incontinence/ peri-care/ brief daily, document the last bowel movement, hair care/ shampoo, mouth care, skin care, nail care, assist with dressing daily, prepare meal, serve meal, encourage fluids daily, laundry, clean bathroom, make/ change bed, clean kitchen and bedroom, vacuum/ sweep, and may take patient outside daily, etc. are completed per the Home Health Aide Care Plan.</p> <p>5. To ensure this deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Administrator/Clinical Manager or Clinical Designee on a quarterly basis to ensure the aide plan of care accurately reflects services ordered in the medical plan of care.</p>

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

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	stated that the home health aide should only be documenting what was performed during the attendant care hours.			