

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157680	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/20/2025	
NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 N GREEN RIVER RD , EVANSVILLE, IN, 47715		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	<p>Initial Comments</p> <p>This visit was for a State Re-licensure Survey of a Home Health provider.</p> <p>Survey Dates: 3/17/2025-3/20/2025</p> <p>12-month Unduplicated Skilled Admissions: 46</p> <p>Abbreviations:</p> <p>RN Registered Nurse</p> <p>LPN Licensed Practice Nurse</p> <p>HHA Home Health Aide</p>	N0000		

<p>N0466</p>	<p>Home health agency administration/management</p> <p>410 IAC 17-12-1(j)</p> <p>Rule 12 Sec. 1(j) The information obtained from the:</p> <p>(1) physical examinations required by subsection (h); and</p> <p>(2) tuberculosis evaluations and clinical follow-ups required by subsection (i)</p> <p>must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k).</p> <p>Based on record review and interview, the agency failed to separate the medical records from the rest of the documents in the personnel file to ensure confidentiality was maintained for 8 of 8 employee records, with the potential to affect all employee records (Alternate Administrator/Clinical Manager, RN 1, RN 2, RN 3, LPN 1, HHA 1, HHA 2, and Recruitment Operations Manager (ROM) 1.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A review of the Alternate Administrator/Clinical Manager's personnel file on 03/20/2025 	<p>N0466</p>	<p>By submitting this POC the agency does not admit theallegations in the survey report or that it violated anyregulations. The agency is submitting this POC in responseto its regulatory obligations and commitment to compliance.The agency further reserves the right to contrast any allegedfindings, conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegationof Compliance.</p> <ol style="list-style-type: none"> 1. Personnel files for RN1, RN2, RN3, LPN1, HHA1, HHA2,and ROM 1 have been corrected with TB evaluations, annualassessments, and physical exams in a separateconfidential file per 410 IAC 17-12-1 (j) effective 4-4-2025. 2. Administrator will educate Field Support Manager onCFR(s) 410 IAC 17-12-1 (j) requirement that information fromthe (1) physical examination (2) TB evaluation and follow upmust be maintained in seperate medical 	<p>2025-04-19</p>

two step TB tests and annual risk assessment forms in the same personnel file as their nursing license, background check, job description, orientation paperwork, and annual performance evaluation.

2. A review of RN 1's personnel file on 03/20/2025 evidenced their initial two step TB tests and annual risk assessment forms in the same personnel file as their nursing license, background check, job description, and orientation paperwork.
3. A review of RN 2's personnel file on 03/20/2025 evidenced their initial two step TB tests and annual risk assessment forms in the same personnel file as their nursing license, background check, job description, orientation paperwork, and annual performance evaluation.
4. A review of RN 3's personnel file on 03/20/2025 evidenced their initial two step TB tests and annual risk assessment forms in the

files and treated as confidential records during weekly meeting by 4-11-2025.

2. Field Support Manager will ensure 100% of current employees files are filed with TB evaluation, annual assessments, and physical exams in separate confidential file per 410 IAC 17-12-1 (j) by 04-19-2025
3. Field Support Manager will audit 100% of new hire personnel files weekly for a minimum of 4 weeks to ensure all confidential information is filed in a separate medical folder. Threshold 100%, once threshold is met, will monitor through quarterly audit process.
4. To ensure the alleged deficiency does not reoccur the Administrator or designee will complete quarterly self-audit review of 10 or 10% (whichever is greater) of active personnel files to ensure compliance with 410 IAC 17-12-(j) Responsible Party:
Administrator and Field Support Manager

same personnel file as their nursing license, background check, job description, and orientation paperwork.

5. A review of LPN 1's personnel file on 03/20/2025 evidenced their initial two step TB tests and annual risk assessment forms in the same personnel file as their nursing license, background check, job description, and orientation paperwork.

6. A review of the Recruitment Operations Manager (ROM)'s personnel file on 03/20/2025 evidenced their initial two step TB tests and annual risk assessment forms in the same personnel file as their nursing license, background check, job description, orientation paperwork, and annual performance evaluation.

7. A review of HHA 1's personnel file on 03/20/2025 evidenced their initial two step TB tests and annual risk assessment form in the same personnel file as their background check

job description, orientation paperwork, and competency exams, skills checklists, required training and in-services.

8. A review of HHA 2's personnel file on 03/20/2025 evidenced their initial two step TB tests and annual risk assessment forms in the same personnel file as their background check, job description, orientation paperwork, annual performance evaluations, and competency exams, skills checklists, required training and in-services.
9. During an interview on 03/20/2025 at 3:40 PM, the Alternate Administrator/Clinical Manager indicated each employee has one (1) file for all records and there isn't another file within for medical records to be kept separate.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

Madison Dischinger

Clinical Manager

4/10/2025 5:30:16 PM
