

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157591	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2018
NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP COD 3000 EAST COLISEUM BLVD STE 300 FORT WAYNE, IN 46805		
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E 0000 Bldg. 00	<p>An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.22 Home Health Agency.</p> <p>Survey Date: December 5, 2018</p> <p>Facility Number: 003757 Provider Number: 157591</p> <p>Census = 39</p> <p>At this Emergency Preparedness survey, Maxim Healthcare Services Inc. was found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 484.22 Home Health Agency.</p>	E 0000		
G 0000 Bldg. 00	<p>This was a federal home health recertification and complaint survey. This was a partial extended survey.</p> <p>Complaint #: IN00220386; Substantiated-deficiencies were cited.</p> <p>Survey Dates: November 27, 28, 29, 30 and December 3, 4, 5, and 10, 2018 Partial Extended Dates: November 28, 29, 30 and December 3, 4, 5, and 10, 2018</p> <p>Facility Number: 003757</p> <p>Medicaid Number: 200484160</p>	G 0000		

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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G 0572 Bldg. 00	<p>Census Service Type: Skilled: 34 Home Health Aide Only: 26 Personal Care Only: 0 Total: 60</p> <p>Sample: RR w/HV: 2 RR w/o HV: 8 Total: 10</p> <p>Based on observation, record review, and interview, the agency failed to ensure plans of care were individualized and visits were provided based on patient needs for 4 of 10 clinical records reviewed. (# 2, 4, 6, and 9)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. The agency's policy titled "Home Health Certification and Plan(s) of Care," # HH-CL-007, effective 7/9/18, stated "3.2. The Plan of Care will be individualized to include, but not limited to, all treatments, procedures, medications, and services authorized to be provided by direct client care staff(s)." 2. The clinical record of patient #2 was reviewed on 11/28/18. The record contained a plan of care with the certification date of 11/5/18-1/3/19 with orders for a skilled nurse (SN) 3-5 days a week for 6-10 hours a week to administer medications. The plan of care failed to evidence the individualized shifts needed for the patient to obtain their medications as evidenced by: 	G 0572	<p>G572 -Plan of Care All internal team members will be educated on Policy # HH-CL-007 "Home Health Certification and Plan(s) of Care" specific to the requirement that the plan of care will be individualized and contain the visit frequency and shifts based on the needs of the patient. This education will be completed by the Clinical Manager by 12/31/18 Beginning 12/20/18, 100% of all patients visit frequency orders will be reviewed over the next 60 days, on or before the recertification to determine if the visit frequency is individualized to the specific patient needs. This will be reviewed by the Clinical Manager or Clinical Designee with the patient/family, and the ordering physician. Care Plans will be updated and new orders received for any visit frequencies that need</p>	01/09/2019

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	<p>During home visit observation on 11/29/18 at 12:00 PM, employee J was observed administering medications to the patient. Employee J stated she came to the house twice daily (at 8 and 12) to administer the medications.</p> <p>During a telephone interview on 12/4/18 at 1:00 PM, the family member of patient # 2 stated they were to have SN 5 days a week for 10 hours each week from 8-9 AM and 12-PM every Monday through Friday. The family member stated as long as they were aware ahead of time that the agency could not staff, then they would be able to make arrangements to adjust work schedule so the family could provide the care. The family member stated they have told the agency they wished they had more staff because they were put in a bind when staff called off at the last minute.</p> <p>3. The clinical record for patient # 4 was reviewed on 11/30/18. The record contained a plan of care with the certification date of 10/20-12/18/18 with orders for SN 67-112 hours a week 4-7 days a week to administer medications and provide bathing. The plan of care failed to evidence the individualized shifts needed for the patient.</p> <p>During a telephone interview on 12/5/18 at 1:50 PM, patient # 4's parent stated the patient did need services 5 days a week, routinely.</p> <p>4. The clinical record for patient # 6 was reviewed on 12/3/18. The record contained a plan of care with the certification date of 11/24/18- 1/22/19 with orders for SN 67-112 hours a week 5-7 days a week to administer medications and provide bathing. The plan of care failed to evidence the individualized shifts needed for the patient.</p>			<p>to be changed based on patient needs and be in line with the authorization.</p> <p>Plans of care for Patients #2, 4, 6, and 9 were reviewed on 12.20.18 by the Clinical Manager/Clinical designee. Plans of care to be reviewed with patient/family and physician by January 9th, 2019 at which time orders will be obtained and care plans updated.</p> <p>On-going, all Plans of Care will include visit frequencies that are individualized to meet the patient needs. Agency will no longer range each patient's visit frequency using a standard 60% range.</p> <p>To ensure this alleged deficiency does not recur, 10 clinical records or 10% of all clinical records, whichever is greater, will be audited quarterly to ensure that the plans of care contain visit frequencies that are individualized to the patient needs.</p> <p>Responsible party: Clinical manager</p> <p>This alleged deficiency will be corrected by 1/09/19</p>

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	<p>During a telephone interview on 12/5/18 at 8:23 AM, the parent for patient #6 stated the lower range of visits would not meet the patient/ family schedule.</p> <p>5. The clinical record for patient # 9 was reviewed on 12/3/18. The record contained a plan of care with the certification date of 11/24/18- 1/22/19 with orders for SN 67-112 hours a week 5-7 days a week to administer medications and provide bathing. The plan of care failed to evidence the individualized shifts needed for the patient.</p> <p>During a telephone interview on 12/5/18 at 8:23 AM, the parent for patient #9 stated the lower range of visits would not meet the patient/ family schedule.</p> <p>6. During an interview on 12/3/18 at 1:35 PM, in response to the visit frequencies not being individualized based on what the patients need, the administrator stated the frequencies have been this way for a long time and that was what the physicians ordered. The administrator stated the agency scheduled 60% yet staffed 100% so that if there was a call in within the range, the agency would be covered.</p> <p>7. During an interview on 12/3/18 at 2:30 PM, the alternate administrator stated the hours were generally approved by prior authorization (PA) and 60% was agreed upon by the families and physicians, based on family needs. The alternate administrator stated the hours were determined by dividing the total amount approved by PA and dividing by 26 weeks (six-month time frames).</p> <p>8. During an interview on 12/5/18 at 2:45 PM, the area vice president stated the agency put the 60% rule in place based on the organization's</p>				

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G 0574 Bldg. 00	<p>reasonable expectations for meeting frequencies and while not needing to notify physicians of missed visits.</p> <p>Based on record review, and interview, the agency failed to ensure the care plan was coordinated with the initial assessment for 1 of 10 clinical records reviewed. (# 3)</p> <p>Findings include</p> <p>1. The agency's policy titled "Home Health Certification and Plan(s) of Care," # HH-CL-007, effective 7/9/18, stated "3.2. The Plan of Care will be individualized to include, but not limited to, all treatments, procedures, medications and services authorized to be provided by direct client care staff(s). ... 5.3. The Plan of Care shall include, but not limited to: ... 5.3.12. A summary of patient findings upon admission. ..."</p> <p>2. The clinical record for patient # 3 was reviewed on 11/28/18. The record contained a plan of care with the certification date of 10/19-12/17/18 with a diagnosis of adult failure to thrive.</p> <p>The initial assessment dated 6/21/18, the nutritional risk section stated "Not a Risk." The plan of care diagnosis failed to be supported by the initial assessment.</p> <p>3. During an interview on 12/5/18 at 2:50 PM, the administrator stated the diagnosis came from the physician.</p>	G 0574	<p>G574 – Plan of Care</p> <p>Education will be provided to all Internal clinical team members on Policy HH-CL-007 Home Health Certification and Plan(s) of Care, focusing on Section 3.2 The Plan of care will be individualized to include, but not limited to, all treatments, procedures, medications and services authorized to be provided by direct care staff; Section 5.3 The Plan of Care shall include, but not limited to: and Section 5.3.12 A summary of patient findings upon admission and following each comprehensive reassessment. Education also to include policy MD-CL-018.7 Case Coordination/Case conference.</p> <p>Education will be provided by 12.20.18</p> <p>Clinical Manager spoke to RN for physician for patient #3 to discuss diagnosis of "Adult failure to thrive" and obtained order to remove diagnosis from plan of care, care plan updated on 12.18.18.</p> <p>Over the next 60 days, beginning on 12.20.18 Clinical Manager will review 100% of admission and recertification documentation to ensure that patient diagnosis is supported by clinical assessment,</p>	12/20/2018

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G 0578 Bldg. 00	<p>Based on observation, record review, and interview, the agency failed to ensure all visits were made as ordered on the plan of care for 3 of 10 clinical records reviewed. (# 2, 6, and 7)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. The agency's policy titled "Missed Shift/Visit," # SOP-MD-CL-016b, effective 1/11/16, stated "5.0 Notify Physician ... Physician notification ... is required when the missed shift/visit causes the care to fall below the physician ordered frequency." 2. The clinical record of patient #2 was reviewed 	G 0578	<p>comprehensive assessment findings coincide, and care coordination has been completed and documented.</p> <p>To ensure this alleged deficiency does not recur, 10 clinical records or 10% of all clinical records, whichever is greater, will be audited quarterly to ensure that the comprehensive assessment findings coincide and support the patient diagnoses.</p> <p>Responsible party: Clinical manager</p> <p>This alleged deficiency will be corrected by 12/20/18</p> <p>Education to be provided by 12/20/18. Documentation review of admissions and recertification's will be completed by 02.28.19</p> <p>G578 – Conformance with Physician Order</p> <p>All internal team members will be educated by Clinical Manager on Policy SOP-MD-CL-016b as well as CFR 484.60(b) "Conformance with physician's orders" and 410 IAC 17-13-1(a) "Patient Care" by 12/31/18.</p> <p>Agency recruiters will complete a 100% review of patient schedules to ensure that the maxim amount of ordered services are scheduled. This review will be completed by 1/09/19.</p> <p>Patient #2 has nursing personnel</p>	01/09/2019

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	<p>on 11/28/18. The record contained a plan of care with the certification date of 9/6-11/4/18 with orders for a skilled nurse (SN) 3-5 days a week for 6-10 hours a week to administer medications. The record failed to evidence the agency provided SN visits on 10/3 noon shift, and both shifts on 10/4, 10/13, 10/20, 10/25, 10/26, 10/10, 10/11, 10/15, 10/17, 10/18, and 10/19/2018.</p> <p>The agency's complaint document dated 10/1/18, evidenced the family of patient # 2 had called and was notified that the regular nurse would not be providing care for the patient that week due to doing some clinic time for the agency. The family member had told the agency they wanted care covered in that nurse's place.</p> <p>During a telephone interview on 12/4/18 at 1:00 PM, the family member of patient # 2 stated they were to have SN 5 days a week for 10 hours each week from 8-9 AM and 12-PM every Monday through Friday. The family member stated as long as they were aware ahead of time that the agency could not staff, then they would be able to make arrangements to adjust work schedule so the family could provide the care. The family member stated they have told the agency they wish they had more staff because they were put in a bind when staff called off at the last minute.</p> <p>An attempt to reach patient # 2's physician was made on 12/5/18 at 12:15 PM; the physician was out for the day so a message was left to ask about the lower end of staffing range and if this would be an acceptable frequency for providing this patient care. On 12/10/18 at 8:30 AM, patient # 2's nurse practitioner for the physician called back and stated they would like to see the patient receive the maximum benefit allowed.</p>			<p>scheduled for 100% of the ordered nursing services as of 12.20.18 Patient #6 has nursing personnel scheduled for 100% of the ordered nursing services as of 12.20.18 Patient #7 has nursing personnel scheduled for 100% of the ordered nursing services as of 12.20.18 Ongoing the Operations Manager will check patient schedules on a weekly basis, beginning week of 12.24.18, to ensure agency recruiters have scheduled staff for 100% of each patients ordered services. On-going, all Plans of Care will include visit frequencies that are individualized to meet the patient needs. Agency will no longer range each patient's visit frequency using a standard 60% range. To ensure this alleged deficiency does not recur, 10 clinical records or 10% of all clinical records, whichever is greater, will be audited quarterly to ensure that the each patient had staff scheduled for 100% of their ordered services as well as to ensure that the plans of care contain visit frequencies that are individualized to the patient needs. This alleged deficiency will be corrected by 1/9/19 Responsible Party: Operations Manager</p>

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	<p>4. The clinical record for patient # 6 was reviewed on 12/3/18. The record contained a plan of care with the certification date of 7/27-9/24/18 with orders for SN 67-112 hours a week 5-7 days a week to administer medications and provide bathing. The record failed to evidence the agency provided SN visits on 8/15, 8/17, 8/18, and 8/19/18.</p> <p>During a telephone interview on 12/5/18 at 8:23 AM, the parent for patient #6 stated the lower range of visits would not meet the patient/family schedule.</p> <p>5. The clinical record for patient # 7 was reviewed on 12/5/18. The record contained a plan of care with the certification date of 8/16-10/14 and 10/15-12/13/18 with orders for SN 22-36 hours a week for 2-4 days a week to assist with activities of daily living and administer tube feedings. The record failed to evidence all visits had been completed as ordered.</p> <p>The missed shifts and hours report dated 8/3-12/4/18 evidenced the agency was unable to find a nurse replacement on 8/17, 9/3, 9/7, 9/18, 9/28, 10/15, 10/26, 11/8, 11/9, and 11/16/18.</p> <p>The agency's complaint log dated 10/29/18 evidenced the parents called to request a new nurse as the current one had missed 11 days recently, therefore, the patient had not been able to attend school. The parent also suggested that the agency review the nurse's time sheets and if there were less than 4 days on them to please call the parents.</p> <p>6. During an interview on 12/3/18 at 1:35 PM, in response to the visit frequencies not being individualized based on what the patients need, the administrator stated the frequencies have</p>				

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G 0602 Bldg. 00	<p>been this way for a long time and that is what the physicians ordered. The administrator stated the agency schedules 60% yet staffs 100% so that if there was a call in within the range, the agency would be covered.</p> <p>7. During an interview on 12/3/18 at 2:30 PM, the alternate administrator stated the hours were generally approved by prior authorization (PA) and 60% is agreed upon by the families and physicians, based on family needs. The alternate administrator stated the hours were determined by dividing the total amount approved by PA and dividing by 26 weeks (six-month time frames).</p> <p>8. During an interview on 12/5/18 at 2:45 PM, the area vice president stated the agency put the 60% rule in place based on the organization's reasonable expectations for meeting frequencies and while not needing to notify physicians of missed visits.</p> <p>Based on record review and interview, the agency failed to ensure the physician was notified of missed visits/ shifts for 1 of 10 clinical records reviewed. (#2)</p> <p>Findings include</p> <p>The agency's policy titled "Missed Shift/Visit," # SOP-MD-CL-016b, effective 1/11/16, stated "5.0 Notify Physician ... Physician notification ... is required when the missed shift/visit causes the care to fall below the physician ordered frequency."</p>	G 0602	<p>G602 – Communication with Physician</p> <p>Education provided to all Office staff members responsible for completed Missed Shift/Visit Forms, including employee O.</p> <p>Education included the following:</p> <p>Policy Md-CL-016.4: Patient/Client Scheduling and SOP-MD-CL 016b: Missed Shift/Visit specific to the requirement to notify Physician of missed shifts for all patients, including nursing shifts.</p> <p>Education completed and acknowledgement signed 11.29.18</p>	12/10/2018

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	<p>The clinical record of patient #2 was reviewed on 11/28/18. The record contained a plan of care with the certification date of 9/6-11/4/18 with orders for a skilled nurse (SN) 3-5 days a week for 6-10 hours a week to administer medications.</p> <p>The record failed to evidence the physician had been notified of the following missed visits/shifts:</p> <ul style="list-style-type: none"> October 10 and 11 for 8-9 AM and 12-1 PM October 12 for 12-1 PM October 15, 17, 18 and 19 from 8-9 AM and 12-1 PM October 22, 23, 25, and 26 from 8-9 AM October 22, 23, and 26 from 12-1 PM November 7, 8, from 8-9 AM November 7, 8 and 9 from 12-1 PM <p>The missed opportunities list for patient #2 evidenced the following statements: On 10/10, 10/11 10/18, 10/22, and 10/23 for both shifts, and on 10/12 from 8-9 indicated "Caregiver Canceled-No Back-Fill." On 10/17 for both shifts, and on 10/25 from 8-9 indicated "Caregiver No Call-No Show." On 10/15 and 10/19 for both shifts indicated "No Qualified Caregiver Available."</p> <p>During an interview on 12/5/18 at 1:23 PM, the administrator stated 'no qualified caregiver available' meant the family did not want different staff to replace the regular staff and 'no back-fill' meant nobody was available to pick up the shift.</p> <p>During an interview on 11/28/18 at 3:00 PM, the administrator stated the recruiters filled out missed visit forms and the clinical supervisors faxed them to the physicians. The administrator stated if the frequency of 3 days a week was met then no missed visit forms would be in the record.</p>		<p>Office process revised to include utilizing Vision System generated reports for Missed shift/visit notification and all Office staff members educated on revised office process. Education completed and Acknowledgements signed on 11.30.18</p> <p>Patient #2 - Missed visit/shift notification forms sent to MD on 11.29.18</p> <p>Ongoing</p> <p>Clinical Manager/Operations Manager will review with team members during weekly Team meeting to validate missed shift/visit notifications forms have been completed and provided to the clinical team for notification to the Physician.</p> <p>Clinical Manager to ensure recruiters complete Missed shift/visit forms and have been provided to the clinical supervisors. Clinical Manager to ensure those forms are being reviewed and faxed to the physicians on a weekly basis.</p> <p>Continue to file Missed shift/visit forms along with successful fax confirmation in the appropriate medical record.</p> <p>To ensure this alleged deficiency does not recur, 10 clinical records or 10% of all clinical records, whichever is greater, will be audited quarterly to ensure that physicians are being notified of missed shifts all patients.</p>	

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G 0684 Bldg. 00	<p>During an interview on 11/28/18 at 3:07 PM, employee O stated the agency did not notify the physicians about missed nursing shifts, only the missed home health aide visits and she did not know they needed to be notified for missed nursing visits.</p> <p>Based on observation, and interview, the agency failed to ensure all staff followed infection control policies and procedures for 2 of 3 home visit observations. (# 1 and 2)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During home visit observation with patient # 2 on 11/29/18, employee J was observed providing care of a g-tube and administering medications. Employee J failed to wash hands for longer than approximately 10 seconds. 2. During home visit observation on 11/30/18 at 9:00 AM with patient # 1, employee M was observed preparing medications for a g-tube (gastric tube) site administration. Employee M donned (applied) clean gloves and proceeded to rinse the syringes and prepare the medications. Employee M administered the medications and then took the supplies back to the kitchen sink to rinse. Employee M then removed the gloves and donned clean gloves. Employee M failed to change gloves prior to administering medications and failed to wash hands or use hand sanitizer in between glove changes. 3. During an interview on 12/5/18 at 2:45 PM, the 		G 0684	<p>This alleged deficiency was corrected on 11.30.18 Education completed on 11.30.18. Follow up discussions will be completed weekly during Team Meetings.</p> <p>G684 – Infection Control In-services provided to all field staff to include the following: Policy MD-ICS-001: Infection Control Program; Policy CORE-ICS-005.4: Hand Hygiene and Handout for "How to Hand Wash" All Field staff to sign acknowledgement of receipt of In-service. Acknowledgements to be filed in each employees personnel file. In-services to be provided to all field staff by January 9th, 2019 Employee J was provided one on one Infection Control and Hand Hygiene training and competency completed 12.17.18. Employee M was provided one on one Infection Control and Hand Hygiene training and competency completed 12.12.18. Infection Control online training module to be assigned to all field staff by January 7th, 2019</p> <p>Over the next 60 days beginning 12.20.18, Internal Clinical Team members will observe all field staff completing proper hand hygiene</p>

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G 0798 Bldg. 00	<p>administrator stated staff should use hand sanitizer or wash hands in between glove changes, and also should change gloves prior to medication administration. The administrator stated hand washes should be 30-45 seconds.</p> <p>Based on record review and interview, the agency failed to ensure the home health aides (HHA) followed the aide care plans for 2 of 3 clinical records reviewed of patients receiving HHA services. (# 2, and 3)</p> <p>Findings include</p> <p>1. The clinical record of patient #2 was reviewed on 11/28/18. The record contained a plan of care with the certification date of 11/5/18-1/3/19 with orders for HHA services 5-7 days a week for 33-56 hours a week to assist with bathing, mobility, toileting, personal care, nutrition, and</p>	G 0798	<p>during recertification visits and document this observation.</p> <p>Re-education to be provided in real time as needed.</p> <p>Clinical Manager will review recertification documentation weekly to ensure hand hygiene observation was completed and documented</p> <p>To ensure this alleged deficiency does not recur, observation of staff performing hand hygiene will occur during Home Visit portion of Agency's on-going Quarterly Self Audits on a minimum of 5 patient home visits per quarter.</p> <p>This alleged deficiency will be corrected by January 9th 2019</p> <p>Responsible party: Clinical Manager</p> <p>G798 Home Health Aide Assignments and Duties Education provided to all home health aides (HHA), including home health aides for patients #2 and #3, on policy HH-CL-008.6 Home Health Aide Plan of Care and JOB AID for Aide Weekly Note on 12/28/18</p> <p>Aide Care plans for Patient #2 were reviewed and updated with a separate care plan for each shift on 12.03.18</p> <p>HHA documentation to be reviewed by clinical supervisors</p>	12/28/2018

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	<p>housekeeping. The record evidenced the HHA hours were split into three shifts per day, the AM, afternoon, and evening. The record failed to evidence separate care plans for each shift, and failed to evidence the HHA followed the aide care plan as described below:</p> <p>The HHA care plan dated 11/2/18, evidenced the following tasks were assigned to be completed daily: bathing of total bed bath, assist shower or partial bath, transfer assist, reposition every 2 hours and passive range of motion (ROM), incontinence/ peri care, incontinent brief, and document last bowel movement (BM), hair care/ shampoo, mouth care, skin care, nail care, assist with dressing, laundry, clean bedroom and bathroom, change/ make bed, clean kitchen, vacuum/ sweep.</p> <p>The HHA morning shift notes dated 11/15, 16, and 17, 2018 failed to evidence the following tasks had been completed: ambulation assist, last BM, and clean kitchen; and on 11/15 and 16 failed to evidence the HHA cleaned the bathroom.</p> <p>The HHA morning shift notes dated 11/11, 12, 13, and 14, 2018 failed to evidence the following tasks had been completed: ambulation and transfer assist, mouth care, skin care, and nail care, change/ make bed, and clean kitchen; and on 11/14, 12, 13, and 14, assist with dressing.</p> <p>The HHA morning shift notes dated 11/5, 6, 7, and 10, 2018 failed to evidence the following tasks had been completed: bathing, ambulation, and transfer assist, nail care, assist with dressing, change/ make bed, and clean kitchen; and on 11/8 and 9, bathing, mouth care, clean bedroom and vacuum; and on 11/9 laundry.</p>		<p>during home visits to ensure plan of care is being followed and documented appropriately.</p> <p>On-going, 25% of the patient census will be reviewed monthly by the clinical team members as part of documentation review to ensure that home health aides are following the plan of care.</p> <p>To ensure this alleged deficiency does not recur, 10 clinical records or 10% of all clinical records, whichever is greater, will be audited quarterly to ensure that plan of care is being followed and documented appropriately.</p> <p>Responsible party: Clinical Manager/Clinical supervisor will complete documentation review as stated above</p> <p>This alleged deficiency will be corrected by 12/28/18</p> <p>Education to all Home Health Aides will be provided by 12/28/18.</p> <p>Additional review to be completed during monthly and quarterly record review.</p>	

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	<p>The HHA morning shift notes dated 11/4, 8, and 9, 2018 failed to evidence the following tasks had been completed: ambulation and transfer assist, and clean kitchen; and on 11/8 and 9, record last BM.</p> <p>2. The clinical record for patient # 3 was reviewed on 11/28/18. The record contained a plan of care with the certification date of 10/19-12/17/18 with orders for HHA 2-3 hours a day, 3-5 days a week to assist with bathing, mobility, toileting, personal care, nutrition, and housekeeping. The record failed to evidence the HHA followed the care plan as below:</p> <p>The HHA care plan dated 11/2/18 evidenced the following tasks were assigned to be completed daily: bathing of assist shower every other day, or partial bath, assist with shaving, transfer assist, assist in/out of bed, reposition, assist with toileting, catheter care, empty catheter bag, document last BM, hair care/shampoo, mouth and denture care, skin and nail care, assist with dressing, prepare and serve meal, encourage fluids, laundry, clean bedroom and bathroom, change/make bed, clean kitchen and vacuum/sweep.</p> <p>The HHA note dated 10/19/18 failed to evidence the following tasks had been completed: assist with shaving, prepare a meal, serve the meal, assist with feeding, and encourage fluids.</p> <p>The HHA notes dated 10/22, 23, 24 25, and 26, 2018 failed to evidence the following tasks had been completed: assist with shaving, prepare a meal, serve the meal, and encourage fluids; and on 10/24, 25, and 26 assist with toileting, catheter care, and empty catheter bag.</p>			

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N 0000 Bldg. 00	<p>The HHA note dated 11/8, 2018 failed to evidence the following tasks had been completed: the housekeeping duties of laundry, clean bedroom, and bathroom, change/make the bed, clean kitchen and vacuum/ sweep.</p> <p>3. During an interview on 11/30/18 at 1:45 PM, the administrator stated there should be a care plan for each aide shift. The administrator stated she was not surprised by the aide documentation, as this has been a constant struggle.</p> <p>This was a home health state licensure and complaint survey.</p> <p>Complaint #: IN00220386; Substantiated-deficiencies were cited.</p> <p>Survey Dates: November 27, 28, 29, 30 and December 3, 4, 5, and 10, 2018</p> <p>Facility Number: 003757</p> <p>Medicaid Number: 200484160</p> <p>Census Service Type: Skilled: 34 Home Health Aide Only: 26 Personal Care Only: 0 Total: 60</p> <p>Sample: RR w/HV: 2 RR w/o HV: 8 Total: 10</p>	N 0000		

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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 agency failed to ensure all staff followed infection control policies and procedures for 2 of 3 home visit observations. (# 1 and 2)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During home visit observation with patient # 2 on 11/29/18, employee J was observed providing care of a g-tube and administering medications. Employee J failed to wash hands for longer than approximately 10 seconds. 2. During home visit observation on 11/30/18 at 9:00 AM with patient # 1, employee M was observed preparing medications for a g-tube (gastric tube) site administration. Employee M donned (applied) clean gloves and proceeded to rinse the syringes and prepare the medications. Employee M administered the medications and then took the supplies back to the kitchen sink to rinse. Employee M then removed the gloves and donned clean gloves. Employee M failed to change gloves prior to administering medications and failed to wash hands or use hand sanitizer in between glove changes. 3. During an interview on 12/5/18 at 2:45 PM, the administrator stated staff should use hand sanitizer or wash hands in between glove changes, and also should change gloves prior to 	N 0470	<p>N470 – 410 IAC 17-12-1(m) Home Health Agency administration/management/ Infection Control In-services provided to all field staff to include the following: Policy MD-ICS-001: Infection Control Program; Policy CORE-ICS-005.4: Hand Hygiene and Handout for "How to Hand Wash" All Field staff to sign acknowledgement of receipt of In-service. Acknowledgements to be filed in each employees personnel file. In-services to be provided to all field staff by January 9th, 2019 Employee J was provided one on one Infection Control and Hand Hygiene training and competency completed 12.17.18. Employee M was provided one on one Infection Control and Hand Hygiene training and competency completed 12.12.18. Infection Control online training module to be assigned to all field staff by January 7th, 2019 Over the next 60 days beginning 12.20.18, Internal Clinical Team members will observe all field staff completing proper hand hygiene during recertification visits and</p>	01/09/2019

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N 0520 Bldg. 00	<p>medication administration. The administrator stated hand washes should be 30-45 seconds.</p> <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 observation, record review, and interview, the agency failed to ensure patients were accepted with the expectation that services/visits would be provided based on patients' needs for 4 of 10 clinical records reviewed. (# 2, 4, 6, and 9)</p>	N 0520	<p>document this observation. Re-education to be provided in real time as needed. Clinical Manager will review recertification documentation weekly to ensure hand hygiene observation was completed and documented</p> <p>To ensure this alleged deficiency does not recur, observation of staff performing hand hygiene will occur during Home Visit portion of Agency's on-going Quarterly Self Audits on a minimum of 5 patient home visits per quarter. This alleged deficiency will be corrected by January 9th 2019 Responsible party: Clinical Manager</p> <p>N520 (G572) – 410 IAC 17-13-1 (a) Patient Care All internal team members will be educated on Policy # HH-CL-007 "Home Health Certification and Plan(s) of Care" specific to the requirement that the plan of care will be individualized and contain</p>	01/09/2019

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	<p>Findings include</p> <p>1. The agency's policy titled "Home Health Certification and Plan(s) of Care," # HH-CL-007, effective 7/9/18, stated "3.2. The Plan of Care will be individualized to include, but not limited to, all treatments, procedures, medications, and services authorized to be provided by direct client care staff(s)."</p> <p>2. The clinical record of patient #2 was reviewed on 11/28/18. The record contained a plan of care with the certification date of 11/5/18-1/3/19 with orders for a skilled nurse (SN) 3-5 days a week for 6-10 hours a week to administer medications. The plan of care failed to evidence the individualized shifts needed for the patient to obtain their medications as evidenced by:</p> <p>During home visit observation on 11/29/18 at 12:00 PM, employee J was observed administering medications to the patient. Employee J stated she came to the house twice daily (at 8 and 12) to administer the medications.</p> <p>During a telephone interview on 12/4/18 at 1:00 PM, the family member of patient # 2 stated they were to have SN 5 days a week for 10 hours each week from 8-9 AM and 12-PM every Monday through Friday. The family member stated as long as they were aware ahead of time that the agency could not staff, then they would be able to make arrangements to adjust work schedule so the family could provide the care. The family member stated they have told the agency they wished they had more staff because they were put in a bind when staff called off at the last minute.</p> <p>3. The clinical record for patient # 4 was reviewed on 11/30/18. The record contained a plan of care</p>		<p>the visit frequency and shifts based on the needs of the patient. This education will be completed by the Clinical Manager by 12/31/18</p> <p>Beginning 12/20/18, 100% of all patients visit frequency orders will be reviewed over the next 60 days, on or before the recertification to determine if the visit frequency is individualized to the specific patient needs. This will be reviewed by the Clinical Manager or Clinical Designee with the patient/family, and the ordering physician. Care Plans will be updated and new orders received for any visit frequencies that need to be changed based on patient needs and be in line with the authorization.</p> <p>Plans of care for Patients #2, 4, 6, and 9 were reviewed on 12.20.18 by the Clinical Manager/Clinical designee. Plans of care to be reviewed with patient/family and physician by January 9th, 2019 at which time orders will be obtained and care plans updated.</p> <p>On-going, all Plans of Care will include visit frequencies that are individualized to meet the patient needs. Agency will no longer range each patient's visit frequency using a standard 60% range.</p> <p>To ensure this alleged deficiency does not recur, 10 clinical records or 10% of all clinical records, whichever is greater, will be</p>	

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	<p>with the certification date of 10/20-12/18/18 with orders for SN 67-112 hours a week 4-7 days a week to administer medications and provide bathing. The plan of care failed to evidence the individualized shifts needed for the patient.</p> <p>During a telephone interview on 12/5/18 at 1:50 PM, patient # 4's parent stated the patient did need services 5 days a week, routinely.</p> <p>4. The clinical record for patient # 6 was reviewed on 12/3/18. The record contained a plan of care with the certification date of 11/24/18- 1/22/19 with orders for SN 67-112 hours a week 5-7 days a week to administer medications and provide bathing. The plan of care failed to evidence the individualized shifts needed for the patient.</p> <p>During a telephone interview on 12/5/18 at 8:23 AM, the parent for patient #6 stated the lower range of visits would not meet the patient/ family schedule.</p> <p>5. The clinical record for patient # 9 was reviewed on 12/3/18. The record contained a plan of care with the certification date of 11/24/18- 1/22/19 with orders for SN 67-112 hours a week 5-7 days a week to administer medications and provide bathing. The plan of care failed to evidence the individualized shifts needed for the patient.</p> <p>During a telephone interview on 12/5/18 at 8:23 AM, the parent for patient #9 stated the lower range of visits would not meet the patient/ family schedule.</p> <p>6. During an interview on 12/3/18 at 1:35 PM, in response to the visit frequencies not being individualized based on what the patients need, the administrator stated the frequencies have</p>		<p>audited quarterly to ensure that the plans of care contain visit frequencies that are individualized to the patient needs.</p> <p>Responsible party: Clinical manager</p> <p>This alleged deficiency will be corrected by 1/09/19</p>	

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N 0522 Bldg. 00	<p>been this way for a long time and that was what the physicians ordered. The administrator stated the agency scheduled 60% yet staffed 100% so that if there was a call in within the range, the agency would be covered.</p> <p>7. During an interview on 12/3/18 at 2:30 PM, the alternate administrator stated the hours were generally approved by prior authorization (PA) and 60% was agreed upon by the families and physicians, based on family needs. The alternate administrator stated the hours were determined by dividing the total amount approved by PA and dividing by 26 weeks (six-month time frames).</p> <p>8. During an interview on 12/5/18 at 2:45 PM, the area vice president stated the agency put the 60% rule in place based on the organization's reasonable expectations for meeting frequencies and while not needing to notify physicians of missed visits.</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 observation, record review, and interview, the agency failed to ensure all visits were made as ordered on the plan of care for 3 of 10 clinical records reviewed. (# 2, 6, and 7)</p> <p>Findings include</p> <p>1. The agency's policy titled "Missed Shift/Visit," # SOP-MD-CL-016b, effective 1/11/16, stated "5.0 Notify Physician ... Physician notification ... is</p>	N 0522	<p>N522 – 410 IAC 17-13-1 (a) Patient Care All internal team members will be educated by Clinical Manager on Policy SOP-MD-CL-016b as well as CFR 484.60(b) "Conformance with physician's orders" and 410 IAC 17-13-1(a) "Patient Care" by 12/31/18. Agency recruiters will complete a 100% review of patient schedules</p>	01/09/2019

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	<p>required when the missed shift/visit causes the care to fall below the physician ordered frequency."</p> <p>2. The clinical record of patient #2 was reviewed on 11/28/18. The record contained a plan of care with the certification date of 9/6-11/4/18 with orders for a skilled nurse (SN) 3-5 days a week for 6-10 hours a week to administer medications. The record failed to evidence the agency provided SN visits on 10/3 noon shift, and both shifts on 10/4, 10/13, 10/20, 10/25, 10/26, 10/10, 10/11, 10/15, 10/17, 10/18, and 10/19/2018.</p> <p>The agency's complaint document dated 10/1/18, evidenced the family of patient # 2 had called and was notified that the regular nurse would not be providing care for the patient that week due to doing some clinic time for the agency. The family member had told the agency they wanted care covered in that nurse's place.</p> <p>During a telephone interview on 12/4/18 at 1:00 PM, the family member of patient # 2 stated they were to have SN 5 days a week for 10 hours each week from 8-9 AM and 12-PM every Monday through Friday. The family member stated as long as they were aware ahead of time that the agency could not staff, then they would be able to make arrangements to adjust work schedule so the family could provide the care. The family member stated they have told the agency they wish they had more staff because they were put in a bind when staff called off at the last minute.</p> <p>An attempt to reach patient # 2's physician was made on 12/5/18 at 12:15 PM; the physician was out for the day so a message was left to ask about the lower end of staffing range and if this would be an acceptable frequency for providing this</p>		<p>to ensure that the maxim amount of ordered services are scheduled. This review will be completed by 1/09/19.</p> <p>Patient #2 has nursing personnel scheduled for 100% of the ordered nursing services as of 12.20.18</p> <p>Patient #6 has nursing personnel scheduled for 100% of the ordered nursing services as of 12.20.18</p> <p>Patient #7 has nursing personnel scheduled for 100% of the ordered nursing services as of 12.20.18</p> <p>Ongoing the Operations Manager will check patient schedules on a weekly basis, beginning week of 12.24.18, to ensure agency recruiters have scheduled staff for 100% of each patients ordered services.</p> <p>On-going, all Plans of Care will include visit frequencies that are individualized to meet the patient needs. Agency will no longer range each patient's visit frequency using a standard 60% range.</p> <p>To ensure this alleged deficiency does not recur, 10 clinical records or 10% of all clinical records, whichever is greater, will be audited quarterly to ensure that the each patient had staff scheduled for 100% of their ordered services as well as to ensure that the plans of care contain visit frequencies that are individualized to the patient needs.</p> <p>This alleged deficiency will be corrected by 1/9/19</p>	

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	<p>patient care. On 12/10/18 at 8:30 AM, patient # 2's nurse practitioner for the physician called back and stated they would like to see the patient receive the maximum benefit allowed.</p> <p>4. The clinical record for patient # 6 was reviewed on 12/3/18. The record contained a plan of care with the certification date of 7/27-9/24/18 with orders for SN 67-112 hours a week 5-7 days a week to administer medications and provide bathing. The record failed to evidence the agency provided SN visits on 8/15, 8/17, 8/18, and 8/19/18.</p> <p>During a telephone interview on 12/5/18 at 8:23 AM, the parent for patient #6 stated the lower range of visits would not meet the patient/family schedule.</p> <p>5. The clinical record for patient # 7 was reviewed on 12/5/18. The record contained a plan of care with the certification date of 8/16-10/14 and 10/15-12/13/18 with orders for SN 22-36 hours a week for 2-4 days a week to assist with activities of daily living and administer tube feedings. The record failed to evidence all visits had been completed as ordered.</p> <p>The missed shifts and hours report dated 8/3-12/4/18 evidenced the agency was unable to find a nurse replacement on 8/17, 9/3, 9/7, 9/18, 9/28, 10/15, 10/26, 11/8, 11/9, and 11/16/18.</p> <p>The agency's complaint log dated 10/29/18 evidenced the parents called to request a new nurse as the current one had missed 11 days recently, therefore, the patient had not been able to attend school. The parent also suggested that the agency review the nurse's time sheets and if there were less than 4 days on them to please call the parents.</p>			Responsible Party: Operations Manager	

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N 0524 Bldg. 00	<p>6. During an interview on 12/3/18 at 1:35 PM, in response to the visit frequencies not being individualized based on what the patients need, the administrator stated the frequencies have been this way for a long time and that is what the physicians ordered. The administrator stated the agency schedules 60% yet staffs 100% so that if there was a call in within the range, the agency would be covered.</p> <p>7. During an interview on 12/3/18 at 2:30 PM, the alternate administrator stated the hours were generally approved by prior authorization (PA) and 60% is agreed upon by the families and physicians, based on family needs. The alternate administrator stated the hours were determined by dividing the total amount approved by PA and dividing by 26 weeks (six-month time frames).</p> <p>8. During an interview on 12/5/18 at 2:45 PM, the area vice president stated the agency put the 60% rule in place based on the organization's reasonable expectations for meeting frequencies and while not needing to notify physicians of missed visits.</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:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. 			

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	<p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on record review, and interview, the agency failed to ensure the care plan was coordinated with the initial assessment for 1 of 10 clinical records reviewed. (# 3)</p> <p>Findings include</p> <p>1. The agency's policy titled "Home Health Certification and Plan(s) of Care," # HH-CL-007, effective 7/9/18, stated "3.2. The Plan of Care will be individualized to include, but not limited to, all treatments, procedures, medications and services authorized to be provided by direct client care staff(s). ... 5.3. The Plan of Care shall include, but not limited to: ... 5.3.12. A summary of patient findings upon admission. ..."</p> <p>2. The clinical record for patient # 3 was reviewed on 11/28/18. The record contained a plan of care with the certification date of 10/19-12/17/18 with a diagnosis of adult failure to thrive. The initial assessment dated 6/21/18 nutritional risk section stated "Not a Risk" and the gastrointestinal section stated "Bowel Sounds Absent, Flatulence Yes ... Last Bowel Movement Date 6/21/2018." The plan of care diagnosis and nutritional</p>	N 0524	<p>N524 – 410 IAC 17-13-1 (a) (1) Patient Care</p> <p>Education will be provided to all Internal clinical team members on Policy HH-CL-007 Home Health Certification and Plan(s) of Care, focusing on Section 3.2 The Plan of care will be individualized to include, but not limited to, all treatments, procedures, medications and services authorized to be provided by direct care staff; Section 5.3 The Plan of Care shall include, but not limited to: and Section 5.3.12 A summary of patient findings upon admission and following each comprehensive reassessment. Education also to include policy MD-CL-018.7 Case Coordination/Case conference.</p> <p>Education will be provided by 12.20.18</p> <p>Clinical Manager spoke to RN for physician for patient #3 to discuss diagnosis of "Adult failure to thrive" and obtained order to remove</p>	12/20/2018

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N 0533 Bldg. 00	<p>assessment failed to coincide and the bowel assessment failed to coincide with the findings.</p> <p>3. During an interview on 12/5/18 at 2:50 PM, the administrator stated the diagnosis came from the physician.</p> <p>410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service.</p> <p>(b) The nursing plan of care must contain the</p>		<p>diagnosis from plan of care, care plan updated on 12.18.18.</p> <p>Over the next 60 days, beginning on 12.20.18 Clinical Manager will review 100% of admission and recertification documentation to ensure that patient diagnosis is supported by clinical assessment, comprehensive assessment findings coincide, and care coordination has been completed and documented.</p> <p>To ensure this alleged deficiency does not recur, 10 clinical records or 10% of all clinical records, whichever is greater, will be audited quarterly to ensure that the comprehensive assessment findings coincide and support the patient diagnoses.</p> <p>Responsible party: Clinical manager</p> <p>This alleged deficiency will be corrected by 12/20/18</p> <p>Education to be provided by 12/20/18. Documentation review of admissions and recertification's will be completed by 02.28.19</p>	

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	<p>following:</p> <p>(1) A plan of care and appropriate patient identifying information.</p> <p>(2) The name of the patient's physician.</p> <p>(3) Services to be provided.</p> <p>(4) The frequency and duration of visits.</p> <p>(5) Medications, diet, and activities.</p> <p>(6) Signed and dated clinical notes from all personnel providing services.</p> <p>(7) Supervisory visits.</p> <p>(8) Sixty (60) day summaries.</p> <p>(9) The discharge note.</p> <p>(10) The signature of the registered nurse who developed the plan.</p> <p>Based on record review and interview, the agency failed to ensure the home health aides (HHA) followed the aide care plans for 2 of 3 clinical records reviewed of patients receiving HHA services. (# 2, and 3)</p> <p>Findings include</p> <p>1. The clinical record of patient #2 was reviewed on 11/28/18. The record contained a plan of care with the certification date of 11/5/18-1/3/19 with orders for HHA services 5-7 days a week for 33-56 hours a week to assist with bathing, mobility, toileting, personal care, nutrition, and housekeeping. The record evidenced the HHA hours were split into three shifts per day, the AM, afternoon, and evening. The record failed to evidence separate care plans for each shift, and failed to evidence the HHA followed the aide care plan as described below:</p> <p>The HHA care plan dated 11/2/18, evidenced the following tasks were assigned to be completed daily: bathing of total bed bath, assist shower or partial bath, transfer assist, reposition every 2</p>	N 0533	<p>N533 – 410 IAC 17-13-2 Nursing Plan of Care</p> <p>Education provided to all home health aides (HHA), including home health aides for patients #2 and #3, on policy HH-CL-008.6 Home Health Aide Plan of Care and JOB AID for Aide Weekly Note on 12/28/18</p> <p>Aide Care plans for Patient #2 were reviewed and updated with a separate care plan for each shift on 12.03.18</p> <p>HHA documentation to be reviewed by clinical supervisors during home visits to ensure plan of care is being followed and documented appropriately.</p> <p>On-going, 25% of the patient census will be reviewed monthly by the clinical team members as part of documentation review to ensure that home health aides are following the plan of care.</p> <p>To ensure this alleged deficiency does not recur, 10 clinical records</p>	12/28/2018

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	<p>hours and passive range of motion (ROM), incontinence/ peri care, incontinent brief, and document last bowel movement (BM), hair care/ shampoo, mouth care, skin care, nail care, assist with dressing, laundry, clean bedroom and bathroom, change/ make bed, clean kitchen, vacuum/ sweep.</p> <p>The HHA morning shift notes dated 11/15, 16, and 17, 2018 failed to evidence the following tasks had been completed: ambulation assist, last BM, and clean kitchen; and on 11/15 and 16 failed to evidence the HHA cleaned the bathroom.</p> <p>The HHA morning shift notes dated 11/11, 12, 13, and 14, 2018 failed to evidence the following tasks had been completed: ambulation and transfer assist, mouth care, skin care, and nail care, change/ make bed, and clean kitchen; and on 11/14, 12, 13, and 14, assist with dressing.</p> <p>The HHA morning shift notes dated 11/5, 6, 7, and 10, 2018 failed to evidence the following tasks had been completed: bathing, ambulation, and transfer assist, nail care, assist with dressing, change/ make bed, and clean kitchen; and on 11/8 and 9, bathing, mouth care, clean bedroom and vacuum; and on 11/9 laundry.</p> <p>The HHA morning shift notes dated 11/4, 8, and 9, 2018 failed to evidence the following tasks had been completed: ambulation and transfer assist, and clean kitchen; and on 11/8 and 9, record last BM.</p> <p>2. The clinical record for patient # 3 was reviewed on 11/28/18. The record contained a plan of care with the certification date of 10/19-12/17/18 with orders for HHA 2-3 hours a day, 3-5 days a week to assist with bathing, mobility, toileting, personal</p>		<p>or 10% of all clinical records, whichever is greater, will be audited quarterly to ensure that plan of care is being followed and documented appropriately.</p> <p>Responsible party: Clinical Manager/Clinical supervisor will complete documentation review as stated above</p> <p>This alleged deficiency will be corrected by 12/28/18</p> <p>Education to all Home Health Aides will be provided by 12/28/18.</p> <p>Additional review to be completed during monthly and quarterly record review.</p>	

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	<p>care, nutrition, and housekeeping. The record failed to evidence the HHA followed the care plan as below:</p> <p>The HHA care plan dated 11/2/18 evidenced the following tasks were assigned to be completed daily: bathing of assist shower every other day, or partial bath, assist with shaving, transfer assist, assist in/out of bed, reposition, assist with toileting, catheter care, empty catheter bag, document last BM, hair care/shampoo, mouth and denture care, skin and nail care, assist with dressing, prepare and serve meal, encourage fluids, laundry, clean bedroom and bathroom, change/make bed, clean kitchen and vacuum/sweep.</p> <p>The HHA note dated 10/19/18 failed to evidence the following tasks had been completed: assist with shaving, prepare a meal, serve the meal, assist with feeding, and encourage fluids.</p> <p>The HHA notes dated 10/22, 23, 24 25, and 26, 2018 failed to evidence the following tasks had been completed: assist with shaving, prepare a meal, serve the meal, and encourage fluids; and on 10/24, 25, and 26 assist with toileting, catheter care, and empty catheter bag.</p> <p>The HHA note dated 11/8, 2018 failed to evidence the following tasks had been completed: the housekeeping duties of laundry, clean bedroom, and bathroom, change/make the bed, clean kitchen and vacuum/ sweep.</p> <p>3. During an interview on 11/30/18 at 1:45 PM, the administrator stated there should be a care plan for each aide shift. The administrator stated she was not surprised by the aide documentation, as this has been a constant struggle.</p>			

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N 0546 Bldg. 00	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:</p> <p>(G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on record review and interview, the agency failed to ensure the physician was notified of missed visits/ shifts for 1 of 10 clinical records reviewed. (#2)</p> <p>Findings include</p> <p>The agency's policy titled "Missed Shift/Visit," # SOP-MD-CL-016b, effective 1/11/16, stated "5.0 Notify Physician ... Physician notification ... is required when the missed shift/visit causes the care to fall below the physician ordered frequency."</p> <p>The clinical record of patient #2 was reviewed on 11/28/18. The record contained a plan of care with the certification date of 9/6-11/4/18 with orders for a skilled nurse (SN) 3-5 days a week for 6-10 hours a week to administer medications.</p> <p>The record failed to evidence the physician had been notified of the following missed visits/ shifts:</p> <p>October 10 and 11 for 8-9 AM and 12-1 PM</p>		N 0546	<p>N546 – IAC 17-14-1 (a)(1)(G) Scope of Services Education provided to all Office staff members responsible for completed Missed Shift/Visit Forms, including employee O. Education included the following: Policy Md-CL-016.4: Patient/Client Scheduling and SOP-MD-CL 016b: Missed Shift/Visit specific to the requirement to notify Physician of missed shifts for all patients, including nursing shifts. Education completed and acknowledgement signed 11.29.18 Office process revised to include utilizing Vision System generated reports for Missed shift/visit notification and all Office staff members educated on revised office process. Education completed and Acknowledgements signed on 11.30.18 Patient #2 - Missed visit/shift notification forms sent to MD on</p>	12/10/2018

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	<p>October 12 for 12-1 PM October 15, 17, 18 and 19 from 8-9 AM and 12-1 PM October 22, 23, 25, and 26 from 8-9 AM October 22, 23, and 26 from 12-1 PM November 7, 8, from 8-9 AM November 7, 8 and 9 from 12-1 PM</p> <p>The missed opportunities list for patient #2 evidenced the following statements: On 10/10, 10/11 10/18, 10/22, and 10/23 for both shifts, and on 10/12 from 8-9 indicated "Caregiver Canceled-No Back-Fill." On 10/17 for both shifts, and on 10/25 from 8-9 indicated "Caregiver No Call-No Show." On 10/15 and 10/19 for both shifts indicated "No Qualified Caregiver Available."</p> <p>During an interview on 12/5/18 at 1:23 PM, the administrator stated 'no qualified caregiver available' meant the family did not want different staff to replace the regular staff and 'no back-fill' meant nobody was available to pick up the shift.</p> <p>During an interview on 11/28/18 at 3:00 PM, the administrator stated the recruiters filled out missed visit forms and the clinical supervisors faxed them to the physicians. The administrator stated if the frequency of 3 days a week was met then no missed visit forms would be in the record.</p> <p>During an interview on 11/28/18 at 3:07 PM, employee O stated the agency did not notify the physicians about missed nursing shifts, only the missed home health aide visits and she did not know they needed to be notified for missed nursing visits.</p>		<p>11.29.18 Ongoing Clinical Manager/Operations Manager will review with team members during weekly Team meeting to validate missed shift/visit notifications forms have been completed and provided to the clinical team for notification to the Physician. Clinical Manager to ensure recruiters complete Missed shift/visit forms and have been provided to the clinical supervisors. Clinical Manager to ensure those forms are being reviewed and faxed to the physicians on a weekly basis. Continue to file Missed shift/visit forms along with successful fax confirmation in the appropriate medical record.</p> <p>To ensure this alleged deficiency does not recur, 10 clinical records or 10% of all clinical records, whichever is greater, will be audited quarterly to ensure that physicians are being notified of missed shifts all patients.</p> <p>This alleged deficiency was corrected on 11.30.18 Education completed on 11.30.18. Follow up discussions will be completed weekly during Team Meetings.</p>	