STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K050	A. BUILDING 00 B. WING	08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAXIM HEALTHCARE SERVICES INC	1716 E DAY ROAD MISHAWAKA, IN 46545

(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
G 0000 Bldg. 00	This visit was a home health federal recertification survey. This was a partial extended survey. Survey Dates: August 5, 6, 7, and 10, 2015 Facility #: 012154 Medicaid Vendor #: 200484160D Census by Service Type (Unduplicated Last 12 Months): 23 Patients, Skilled 22 Patients, Home Health Aide Only 0 Patients, Personal Services Only Total: 45 Patients Current Census at Time of Survey: 35 QA: LD, R.N.	G 0000		
G 0108 Bldg. 00	484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished. The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be			

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

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

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	furnished. The HHA must advise the patient in advance of any change in the plan of care before the change is made. Based on clinical record review, policy review, and interview, the agency failed to ensure the patient was informed, in advance, of any changes in the care to be furnished in 1 of 8 active patient records reviewed. (#2) Findings include: 1. Clinical record #2 contained a physician's plan of care for certification period 6/30 to 8/28/15 with orders to include home health aide services 3-5 days per week for a total of 16-20 hours per week for 60 days to assist with personal care. The record failed to evidence a scheduled home health aide visit was conducted on 7/9/15 and failed to evidence documentation of the patient's notification prior to the missed visit. On 8/10/15 at 2:35 PM, employee A (administrator) indicated a visit should have been conducted on 7/9/15 but was unable to locate documentation of the missed visit. 2. The agency policy titled	G 0108	G-108 1. Patient #2 has been receiving services according to orders on the plan of care.2. DOCS/AO will educate entire staff via in-service at staff meeting on ensuring that the patients are informed, in advance, of any changes in the care to be furnished,including appropriate documentation of logging patient notification. This will be completed by September 9, 2015. 3. DOCS/AO/designee to review 100% of missed visit notifications weekly for 30 days to ensure that all notifications were completed as required.4. 10% of all clinical records will be audited quarterly for evidence that patients have been notified of any modifications to the frequency of visits, or service/care plan by DOCS/designee.5. The DOCS/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur. By submitting this POC the agency does no tadmit 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,	09/09/2015

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	"Patient/Client Rights and Responsibilities" states, "POLICY: 3.1. Each patient/client will be an active, informed participant in their plan of care. ... 5. PATIENT/CLIENT RIGHTS: ... 5.2. Home care patients/clients have the right to: ... 5.2.6. Be fully informed in advance about service/care to be provided, including the disciplines that furnish care and the frequency of visits as well as modifications to the service/care plan."		conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.	
G 0158 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record review, policy review, and interview, the agency failed to ensure the visits were made as ordered on the plan of care in 2 of 8 active patients records reviewed. (#1 and #2) Findings include: 1. Clinical record #1 contained physician's plan of care for certification period 7/10 to 9/7/15 with orders for skilled nursing services 5-6 days per	G 0158	G-0158 1. Specifically, Patient #1 will be referred to management for discharge as we are unable to staff due to family refusal of nurses. Patient #2 has been receiving staffing according to the plan of care. 2. DOCS/AO will educate entire staff	09/09/2015

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	week for a total of 29-48 hours per week for 60 days. A. The record evidenced skilled nursing visits were conducted on 7/7/15 totaling 8 hours, 5 minutes and 7/9/15 totaling 10 hours 1 minute for week 1. The record failed to evidence visits were conducted weeks 2, 3, and 4. B. The record evidenced a document dated 7/13/15 by employee U (office staff) titled "Missed Visit/Shift Notification" stating, "Patient Name [patient #1] ... Scheduled Visit/Shift: Date (s) and Time 7/09 6a [AM] - 6p [PM] & 7/10/15 6a - 12p Type of Visit/Shift Missed: RN [registered nurse]/LPN [licensed practical nurse] -LVN [licensed vocational nurse] [checked] Reason Visit/Shift Missed: Employee Availability [checked] ... ." C. The record evidenced a document dated 7/21/15 by employee U (office staff) titled "Missed Visit/Shift Notification" stating, "Patient Name [patient #1] ... Scheduled Visit/Shift: Date (s) and Time 7/13 4p-10p; 7/14 6a-2p; 7/15 6a-4p; 7/16 & 7/18 6a-6p, 7/17/15 6a-12p Type of Visit/Shift Missed: RN/LPN-LVN [checked] Reason Visit/Shift Missed: Employee Availability [checked] ... ."		(including employee U and employee V) via in-service at staff meeting on the requirement of providing visits/services as ordered on the physician ordered plan of care. Education to include that all qualified caregivers are to be contacted to cover open shifts with accurate documentation via missed shift reports and loggings. This will be completed by September 09, 2015 3. DOCS/AO/designee to review 100% of missed visit notifications weekly for 30 days to ensure that all qualified caregivers were contacted to cover open shifts with accurate documentation via missed shift reports as to reason for missed visit and initials of caregivers contacted. Refusals of	

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	D. The record evidenced a document dated 7/29/15 by employee U (office staff) titled "Missed Visit/Shift Notification" stating, "Patient Name [patient #1] ... Scheduled Visit/Shift: Date (s) and Time 7/20 4p-10p, 7/21 6a-2p, 7/22 6a-4p, 7/23 6a-6p, 7/24/15 6a-12p Type of Visit/Shift Missed: RN/LPN-LVN Reason Visit/Shift Missed: Employee Availability [checked] ... ." E. The record evidenced a document dated 8/4/15 by employee V (office staff) titled "Missed Visit/Shift Notification" stating, "Patient Name [patient #1] ... Scheduled Visit/Shift: Date (s) and Time 7/27 4p-10p, 7/26 6a-2p, 7/29 6a-4p, 7/30 6a-6p, 7/31/15 6a-12p and 8/01/15 6a-6p Type of Visit/Shift Missed: RN/LPN-LVN [checked] Reason Visit/Shift Missed: Employee Availability [checked] ... ." F. On 8/10/15 at 2:55 PM, employee B (alternate administrator/director of nursing) indicated the patient's primary caregiver "Keeps refusing our staff." The employee indicated several attempts have been made to staff the patient with skilled nurses, but the patient's caregiver either refuses or "Scares" them off and then the skilled nurse refuses to go back.		caregivers by patient or family will be accurately documented via loggings. 4. 10% of all clinical records will be audited quarterly for evidence that visits/services were rendered as ordered. 5. The DOCS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur. 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.	

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	Employee B indicated currently having a skilled nurse on staff that has conducted a recent visit and will continue providing services as long as the caregiver accepts the skilled nurse's services but if the caregiver refuses, the agency will have no other option but to give a five day notice of discharge. 2. Clinical record #2 contained a physician's plan of care for certification period 6/30 to 8/28/15 with orders to include home health aide services 3-5 days per week for a total of 16-20 hours per week for 60 days to assist with personal care. The record failed to evidence a scheduled home health aide visit was conducted on 7/9/15. On 8/10/15 at 2:35 PM, employee A (administrator) indicated a visit should have been conducted on 7/9/15 but was unable to locate documentation of the missed visit. 3. The agency policy with an effective date of 6/22/15 titled "Home Health Certification and Plan(s) of Care" states, "PURPOSE: 2.1. To provide direct care staff with the physician ordered treatments, procedures, medications, and services required to meet the patient's home care needs. ... ."			

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G 0332 Bldg. 00	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. Based on clinical record review, policy review, and interview, the agency failed to ensure the initial assessment visit was held either within 48 hours of referral or on the physician-ordered start of care date in 3 of 8 active patient records reviewed. (#1, #2, and #3) Findings include: 1. Clinical record #1, start of care 5/11/15, evidenced a physician's order dated 3/24/15 signed by the primary physician stating, "Evaluate [patient] for home-care services dx: [diagnosis] anoxic encephalopathy spastic quad. [quadriplegia]." The record failed to evidence the initial assessment visit was conducted within 48 hours of referral or on the physician ordered start of care date. A. The record contained a document titled "Patient Referral Information" stating, "Date of Referral '3/24/15' RN [registered nurse]/LVN [licensed	G 0332	G-0332 1. DOCS/AO will educate entire staff via in-service at staff meeting by September 9, 2015 on the requirement of ensuring initial assessment visit is completed within 48 hours of receipt of referral, or within 48 hours of the patients return home, or on the physician-ordered start of care date; documentation of all communication; notification of acceptance or rejection of referral within 48 hours. 2. AO to educate staff on new process: Receipt of referral ; contact patient within 12 hours to obtain needed information and schedule evaluation; contact physician within 12 hours for order to evaluate. Evaluation meeting within 48 hours. If unable to staff – reject referral, but keep on 'needs' list. If staff recruitment is successful , contact referral source to see if need still exists. If need exists, get re-referral, initiate PRIF, DR order for start of care and admit for services. 3. DOCS/AO to review 100% of PRIFS (Patient referral information forms) for 30 days to ensure that time frame for	09/09/2015

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	vocational nurse]/LPN [licensed practical nurse] Signature [employee C, Registered Nurse] ... 'Called [primary physician]'s office for H&P [history and physical] and order to evaluate ... ." B. The record evidenced a document titled "Communication Note" stating, "4/23/15 Home Visit made by [employee C, Registered Nurse] ... to meet with family and further evaluate needs." C. On 8/10/15 at 3:05 PM, employee B (alternate administrator, director of nursing) indicated the date of referral was 3/24/15 and the initial evaluation assessment was not conducted until 4/23/15. 2. Clinical record #2, start of care 6/30/15, evidenced a physician's order dated 4/29/15 signed by the primary physician stating, "Home Health Aide Services Eval [evaluate] [and] Treat." The record failed to evidence the initial assessment visit was conducted within 48 hours of referral or on the physician ordered start of care date. A. The record contained a document titled "Patient Referral Information" stating, "Date of Referral '4/20/15' RN/LVN/LPN Signature [employee B, Director of Nursing] ... '5-8-15		response is met. 4. 10% of all clinical records will be audited quarterly for evidence that an assessment was completed on all referrals within 48 hours of referral , or within 48 hours of patient's return home, or on the physician-ordered start of care. 5. The AO will be responsible for monitoring these corrective actions to ensure that this deficiency does not recur. 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.	

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	Assessment completed. Need to find staff in area. Client states [he/she] is flexible in start time' ... ." B. On 8/10/15 at 2:20 PM, employee A (administrator) indicated the date of referral was 4/20/15, a physician's order to assess the patient was dated 4/29/15, and the initial evaluation was not conducted until 5/8/15. 3. Clinical record #3, start of care 5/26/15, evidenced a physician's order dated 4/13/15 signed by the primary physician stating, "Home Healthcare evaluation [and] treat." The record failed to evidence the initial assessment visit was conducted within 48 hours of referral or on the physician ordered start of care date. A. The record contained a document titled "Patient Referral Information" stating, "Date of Referral '3/30/15'." B. On 8/10/15 at 2:40 PM, employee B (alternate administrator, director of nursing) indicated a referral for services was received on 3/30/15 and an initial evaluation assessment was not conducted until 5/12/15. 4. The agency policy with an effective date of 9/1/14 titled "Assessment" states,			

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	"PURPOSE: To define the timelines and process for patient/client assessment. POLICY: 3.1. Each client/patient referred for services will have an initial assessment, as per state licensure, rules or regulations. ... ."			
N 0000 Bldg. 00		N 0000		
	This visit was a home health state re-licensure survey. Survey Dates: August 5, 6, 7, and 10, 2015 Facility #: 012154 Medicaid Vendor #: 200484160D Census by Service Type (Unduplicated Last 12 Months): 23 Patients, Skilled 22 Patients, Home Health Aide Only 0 Patients, Personal Services Only Total: 45 Patients Current Census at Time of Survey: 35 QA; LD, R.N.			
N 0506	410 IAC 17-12-3(b)(2)(D)(iii) Patient Rights			

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Bldg. 00	Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (iii) The home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice. Based on clinical record review, policy review, and interview, the agency failed to ensure the patient was informed, in advance, of any changes in the care to be furnished in 1 of 8 active patient records reviewed. (#2) Findings include: 1. Clinical record #2 contained a physician's plan of care for certification period 6/30 to 8/28/15 with orders to include home health aide services 3-5 days per week for a total of 16-20 hours per week for 60 days to assist with personal care. The record failed to evidence a scheduled home health aide visit was conducted on 7/9/15 and failed to evidence documentation of the patient's notification prior to the missed visit. On 8/10/15 at 2:35 PM, employee A (administrator) indicated a visit should	N 0506	N 0506 1. Patient #2 has been receiving services according to orders on the plan of care. 2. DOCS/AO will educate entire staff via in-service at staff meeting on ensuring that the patients are informed, in advance, of any changes in the care to be furnished,including appropriate documentation of logging patient notification. This will be completed by September 9, 2015. 3. DOCS/AO/designee to review 100% of missed visit notifications weekly for 30 days to ensure that all notifications were completed as required. 4. 10% of all clinical records will be audited quarterly for evidence that patients have been notified of any modifications to the frequency of visits, or service/care plan by DOCS/designee. 5. The DOCS/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur. By submitting this POC the agency does not admit the allegations in the survey report or that it violated any	09/09/2015

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	have been conducted on 7/9/15 but was unable to locate documentation of the missed visit. 2. The agency policy titled "Patient/Client Rights and Responsibilities" states, "POLICY: 3.1. Each patient/client will be an active, informed participant in their plan of care. ... 5. PATIENT/CLIENT RIGHTS: ... 5.2. Home care patients/clients have the right to: ... 5.2.6. Be fully informed in advance about service/care to be provided, including the disciplines that furnish care and the frequency of visits as well as modifications to the service/care plan."		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.	
N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure the visits were made as ordered on the plan of care in 2 of 8 active patients records reviewed. (#1 and #2) Findings include:	N 0522	N 0522 1. Specifically, Patient #1 will be referred to management for discharge as we are unable to staff due to family refusal of nurses.	09/09/2015

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MAXIM HEALTHCARE SERVICES INC	1716 E DAY ROAD MISHAWAKA, IN 46545

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	1. Clinical record #1 contained physician's plan of care for certification period 7/10 to 9/7/15 with orders for skilled nursing services 5-6 days per week for a total of 29-48 hours per week for 60 days. A. The record evidenced skilled nursing visits were conducted on 7/7/15 totaling 8 hours, 5 minutes and 7/9/15 totaling 10 hours 1 minute for week 1. The record failed to evidence visits were conducted weeks 2, 3, and 4. B. The record evidenced a document dated 7/13/15 by employee U (office staff) titled "Missed Visit/Shift Notification" stating, "Patient Name [patient #1] ... Scheduled Visit/Shift: Date (s) and Time 7/09 6a [AM] - 6p [PM] & 7/10/15 6a - 12p Type of Visit/Shift Missed: RN [registered nurse]/LPN [licensed practical nurse] -LVN [licensed vocational nurse] [checked] Reason Visit/Shift Missed: Employee Availability [checked] ... ." C. The record evidenced a document dated 7/21/15 by employee U (office staff) titled "Missed Visit/Shift Notification" stating, "Patient Name [patient #1] ... Scheduled Visit/Shift: Date (s) and Time 7/13 4p-10p; 7/14 6a-		Patient #2 has been receiving staffing according to the plan of care. 2. DOCS/AO will educate entire staff (including employee U and employee V) via in-service at staff meeting on the requirement of providing visits/services as ordered on the physician ordered plan of care. Education to include that all qualified caregivers are to be contacted to cover open shifts with accurate documentation via missed shift reports and loggings. This will be completed by September 09, 2015. 3. DOCS/AO/designee to review 100% of missed visit notifications weekly for 30 days to ensure that all qualified caregivers were contacted to cover open shifts with accurate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K050	A. BUILDING 00 B. WING	08/10/2015

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	2p; 7/15 6a-4p; 7/16 & 7/18 6a-6p, 7/17/15 6a-12p Type of Visit/Shift Missed: RN/LPN-LVN [checked] Reason Visit/Shift Missed: Employee Availability [checked] ... ." D. The record evidenced a document dated 7/29/15 by employee U (office staff) titled "Missed Visit/Shift Notification" stating, "Patient Name [patient #1] ... Scheduled Visit/Shift: Date (s) and Time 7/20 4p-10p, 7/21 6a-2p, 7/22 6a-4p, 7/23 6a-6p, 7/24/15 6a-12p Type of Visit/Shift Missed: RN/LPN-LVN Reason Visit/Shift Missed: Employee Availability [checked] ... ." E. The record evidenced a document dated 8/4/15 by employee V (office staff) titled "Missed Visit/Shift Notification" stating, "Patient Name [patient #1] ... Scheduled Visit/Shift: Date (s) and Time 7/27 4p-10p, 7/26 6a-2p, 7/29 6a-4p, 7/30 6a-6p, 7/31/15 6a-12p and 8/01/15 6a-6p Type of Visit/Shift Missed: RN/LPN-LVN [checked] Reason Visit/Shift Missed: Employee Availability [checked] ... ." F. On 8/10/15 at 2:55 PM, employee B (alternate administrator/director of nursing) indicated the patient's primary caregiver "Keeps refusing our staff." The		documentation via missed shift reports as to reason for missed visit and initials of caregivers contacted. Refusals of caregivers by patient or family will be accurately documented via loggings. 4. 10% of all clinical records will be audited quarterly for evidence that visits/services were rendered as ordered. 5. The DOCS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur. 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.	

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	employee indicated several attempts have been made to staff the patient with skilled nurses, but the patient's caregiver either refuses or "Scares" them off and then the skilled nurse refuses to go back. Employee B indicated currently having a skilled nurse on staff that has conducted a recent visit and will continue providing services as long as the caregiver accepts the skilled nurse's services but if the caregiver refuses, the agency will have no other option but to give a five day notice of discharge. 2. Clinical record #2 contained a physician's plan of care for certification period 6/30 to 8/28/15 with orders to include home health aide services 3-5 days per week for a total of 16-20 hours per week for 60 days to assist with personal care. The record failed to evidence a scheduled home health aide visit was conducted on 7/9/15. On 8/10/15 at 2:35 PM, employee A (administrator) indicated a visit should have been conducted on 7/9/15 but was unable to locate documentation of the missed visit. 3. The agency policy with an effective date of 6/22/15 titled "Home Health Certification and Plan(s) of Care" states, "PURPOSE: 2.1. To provide direct care			

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	staff with the physician ordered treatments, procedures, medications, and services required to meet the patient's home care needs. ... ."			