

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157679	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/07/2020
NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP COD 5265 COMMERCE DRIVE, STE E CROWN POINT, IN 46307		
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E 0000 Bldg. 00	<p>This visit was for a Complaint / Federal Focused Infection Control and some aspects of Emergency Preparedness.</p> <p>Survey Dates: 8/3/2020 - 8/7/2020</p> <p>Facility: IN004862</p> <p>Unduplicated Census: 80</p> <p>Current Census: 80</p> <p>Sample Selection:</p> <p>Home Visits: 2</p> <p>Total clinical records reviewed: 7</p> <p>At this Focused Infection Control Emergency Preparedness survey, in regards to staffing and implementation of staffing, Maxim Healthcare Services was found to be in compliance with 42 CFR 484.102 Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers for Home Health Agencies.</p>	E 0000		
G 0000 Bldg. 00	<p>This visit was a Complaint / Federal Focused Infection Control Survey.</p> <p>Complaint:</p> <p>IN00211469 - substantiated with related and unrelated findings</p> <p>IN00291962 - substantiated with related and unrelated findings</p> <p>IN00295964 - substantiated with related and</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 0434 Bldg. 00	<p>unrelated findings</p> <p>Survey Dates: 8/3/2020 - 8/7/2020</p> <p>Facility: IN004862</p> <p>Unduplicated Census: 80</p> <p>Current Census: 80</p> <p>Sample Selection:</p> <p>Home Visits: 2</p> <p>Total clinical records reviewed: 7</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to state form for additional state findings.</p> <p>Quality Review Completed 08/21/2020 Area 1</p> <p>484.50(c)(4)(i,ii,iii,iv,v,vi,vi,vi,vi)</p> <p>Participate in care</p> <p>Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to--</p> <ul style="list-style-type: none"> (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment 			

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	<p>effectiveness; and</p> <p>(viii) Any changes in the care to be furnished. Based on record review and interview, the agency failed to ensure the patient was informed of the change in the plan of care related to the frequency of skilled nursing visits in 1 of 3 records receiving skilled nursing services in a total sample of 7 clinical records reviewed. (#2)</p> <p>The findings include:</p> <p>Review of an agency policy revised 4/20/2020 titled "Patient/Client Rights and Responsibilities" stated, "... Each patient/client will be an active, informed participant in their plan of care. To ensure this process, the patient/client will be empowered with certain rights and responsibilities. ... A patient/client may designate someone to act as his/her representative ... to act as a patient's/client's legal representative. This authorized representative may exercise any of the rights provided by the policies and procedures on behalf of the patient/client. ... Home care patients/clients have the right to: ... Participate in, be informed about and consent or refuse care in advance of and during treatment, with respect to: ... The frequency of visits ... Receive all services outlined in the plan of care and be informed, in advance, of any changes [sic] to the plan of care...."</p> <p>Clinical record review on 8/4/2020 for patient #2 evidenced an agency document titled "Agreement For Homecare Services" dated by the patient's responsible party on 11/13/18 which indicated the patient was to receive 77-128 hours a week, 4-7 days a week of skilled nursing services.</p> <p>Record review of an agency document titled "Plan of Care" for certification period 3/16/19 - 5/14/19</p>	G 0434	<p><i>Disclaimer:</i> <i>By submitting this POC the agency does not admit the allegations in the survey report or that it is 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to ensure the patient was informed of the change in plan of care related to the frequency of skilled nursing visits.</p> <p>1. Patient #2 was discharged on May 6, 2020.</p> <p>2. Administrator educated all internal staff, including Clinical Supervisors, Recruiters and Field Support, on policy "Patient/Client Rights and Responsibilities" regarding the requirement that each patient/client will be an active, informed participant in their plan of care, including the right to be informed about and consent or</p>	08/20/2020

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	<p>evidenced the patient was to receive skilled nursing services for 68-112 hours a week, 4-7 days a week. The clinical record failed to evidence the patient's responsible party was informed of the change in skilled nursing frequency.</p> <p>Record review of an agency document titled "Plan of Care" for certification period 1/10/2020 - 3/9/2020 evidenced the patient was to receive skilled nursing services for 40-66 hours a week, 4-7 days a week. The clinical record failed to evidence the patient's responsible party was informed of the change in skilled nursing frequency to 40-66 hours a week, 4-7 days a week.</p> <p>During an interview on 8/7/2020 at 11:50 a.m., the alternate administrator indicated although there was email correspondence about the change of the patient's insurance between himself and the patient's legal guardian, it did not indicate the patient's legal guardian was informed of the change in frequency.</p> <p>17-12-3(b)(2)(D)(iii)</p>		<p>refuse care in advance of or during treatment with respect to frequency of visits, receive all services outlined in the plan of care and be informed, in advance, of any changes to the plan of care.</p> <p>This education was provided to all clinical supervisors during a clinical team meeting on August 19, 2020 as evidenced by the meeting agenda and signed education acknowledgement.</p> <p>This education was provided to all recruiters and field support during an office team meeting on August 20, 2020 as evidenced by signed education acknowledgement.</p> <p>3. Ongoing, the Administrator or Designee will be responsible for informing the responsible party of changes in frequency as evidence by documented logging.</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure documentation accurately reflects that the</p>	

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G 0528 Bldg. 00	<p>484.55(c)(1) Health, psychosocial, functional, cognition The patient's current health, psychosocial, functional, and cognitive status; Based on observation, record review and interview, the agency failed to ensure the comprehensive assessment accurately reflected the patient's current health, psychosocial, functional and cognitive status in 1 of 2 clinical records reviewed with a home visit. (#1)</p> <p>The findings include:</p> <p>Review of an agency policy revised 4/22/19 titled "Reassessments/Recertifications" stated, "... A follow-up comprehensive assessment or recertification is conducted by a qualified clinician to identify the patient's current health status ... The comprehensive assessment must be updated and revised ... as frequently as the patient's condition warrants ... The update of the comprehensive follow-up assessment must, at a minimum, include: ... Completion of a comprehensive assessment to reflect any changes in the patient status...."</p> <p>Review of an agency policy revised 9/12/16 titled "Wound Care" stated, "... Documentation of wound measurement(s) will be noted and include a description of: ... wounds size; length; width and</p>	G 0528	<p>responsible party was informed of changes in frequency.</p> <p>Responsible Party: Administrator</p> <p>Date of Completion: August 20, 2020</p> <p><i>Disclaimer: By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to individualize the plan of care to include all medications, supplies, and equipment and patient specific interventions.</p>	09/04/2020

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	<p>depth. ... Wound bed tissue: type/color, necrotic, slough, eschar, granulating and epithelial ... Evidence of wound healing or deterioration"</p> <p>During an observation of care at the home of patient #1 on 8/4/2020 at 10:14 a.m. with employee C, registered nurse (RN), and employee F, home health aide (HHA), present, a tube placed into the patient's abdomen was noted. At 10:29 a.m., soft restraints were observed attached to the side rails on each side of the bed. At 10:38 a.m., 4 wounds and 1 scar were noted to the top of the patient's left hand.</p> <p>Clinical record review on 8/4/2020 for patient #1 evidenced an agency document titled "Plan of Care" for certification period 7/21/2020 - 9/18/2020 which indicated the patient received g-tube (a tube surgically inserted into the stomach through the abdomen to deliver nutrition) feedings.</p> <p>Record review on 8/6/2020 for patient #1 evidenced an agency document titled "Assessment" dated 8/4/2020 and completed by employee C, RN, which indicated the patient did not have a feeding tube (a tube surgically inserted into the abdomen to deliver nutrition). The document further stated, "... pt [patient] bites the back of her hand as part of her behaviors. skin is discolored from past injuries. ... no open areas. apprx [approximately] 5 small areas of scabs noted...." The document failed to include an assessment of the patient's g-tube to include patency, size and assessment of the g-tube site such as skin color and drainage. The document also failed to include an assessment of the wounds to include size, location and color of surrounding skin. The document failed to include an assessment of the family's use of restraints on the patient.</p>		<p>1. Employee F was provided education on August 13th 2020 by Clinical Supervisor as evidenced by logging in personnel file.</p> <p>Administrator educated 100% of clinical supervisors on the requirement for Home Health Certifications and Recertification for completion to include, but not be limited to, listing all medications including OTC, equipment, and supplies.</p> <p>This education was provided to all clinical supervisors during a clinical team meeting on August 27, 2020 as evidenced by the meeting agenda and signed education acknowledgement.</p> <p>2. The clinical supervisor will audit 100% of the patient Plans of care for accuracy of current medications, equipment, and supplies.</p> <p>The Administrator will review 100% recertifications weekly to ensure the patients current medication, including OTC, equipment, and supplies are updated and reflected in the documentation within 30 days.</p>	

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	<p>During an interview on 8/4/2020 at 10:33 a.m., employee F, home health aide (HHA), indicated she has been caring for the patient for 5 years and the restraints have been there for as long as she can remember. Employee F indicated at times the family uses the restraints when the patient bites her hand. Employee F also indicated the patient usually has wounds to her left hand due to biting herself.</p> <p>During an interview on 8/4/2020 at 10:43 a.m., the alternate clinical supervisor indicated she is aware of the wounds to the left hand and stated, "They come and go."</p> <p>During an interview on 8/6/2020 at 5:05 p.m., the clinical supervisor indicated the scabs are eschar (a collection of dead tissues within the wound) and implied that eschar is a description of a wound. The clinical supervisor indicated the comprehensive assessment should include the use of restraints on the patient by the family, assessment of the wounds to include location, size, color of surrounding skin and drainage and assessment of the g-tube to include patency, size and assessment of the g-tube site such as skin color and drainage.</p> <p>17-14-1(a)(1)(B)</p>		<p>3. Ongoing the clinical supervisors will continue to review Plans of care for accuracy of current medications, equipment, and supplies during the recertification process</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure the aide plan of care accurately reflects services ordered in the medical plan of care</p> <p>Responsible Party: Administrator</p> <p>Date of completion 9/4/2020</p> <p><i>Disclaimer:</i> <i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p>	

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			<p>The agency failed to ensure the comprehensive assessment accurately reflected the patient's current health, psychosocial, functional and cognitive status and failed to ensure all medications the patient was currently taking were reviewed.</p> <p>1.Employee C (Clinical Supervisor) was educated 1:1 by administrator on 8/26/2020</p> <p>Patient #1 EMR has been updated with the following effective 8/26/2020:</p> <ul style="list-style-type: none"> ·Assessment 8/4/2020- added a late logging of correction noting GT assessment missed and include detailed info. ·Logging, supplemental order for new medication profile added for medication noted during 8/4/2020 visit. ·Updated wound documentation in POC. ·Added family use of restraints and follow up with physician for supplemental order ·Family education provided regarding safe use of restraints 	

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			<ul style="list-style-type: none"> ·New assessment and care coordination with other agency completed 8/26/2020. ·DME and safety precautions updated. ·HHA written plan of care updated. <p>The Administrator educated 100% of clinical supervisors on the requirement for assessments to reflect current health, psychosocial, functional and cognitive status, and review all medications and treatments for accuracy.</p> <p>This education occurred on 8/27/2020 as evidenced by meeting agenda and signed acknowledgment.</p> <p>2. The clinical supervisors will review and update as necessary 100% of the patients medication profiles for accuracy of current medications.</p> <p>The Administrator will review 100% recertification assessments weekly to ensure the patients current health, psychosocial, functional and cognitive status,</p>	

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G 0536 Bldg. 00	484.55(c)(5) A review of all current medications A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.		<p>and medication reconciliation, are updated and reflected in the documentation within 30 days.</p> <p>3. The clinical supervisors will continue to complete comprehensive assessment as part of the admission and recertification process.</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure the aide plan of care accurately reflects services ordered in the medical plan of care.</p> <p>Party responsible Administrator Date of Completion: 9/04/2020</p>	

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	<p>Based on observation, record review and interview, the home health agency failed to review all medications the patient is currently using in order to identify any potential adverse effects and drug reactions in 1 of 2 home visits conducted in a total sample of 7 clinical records reviewed. (#1)</p> <p>The findings include:</p> <p>Review of an agency policy revised 4/22/19 titled "Reassessments/Recertifications" stated, "... A follow-up comprehensive assessment or recertification is conducted by a qualified clinician to identify the patient's current health status ... The comprehensive assessment must be updated and revised ... as frequently as the patient's condition warrants ... The update of the comprehensive follow-up assessment must, at a minimum, include: ... Completion of a comprehensive assessment to reflect any changes in the patient status. ... Drug regimen review of all medications to include: ... Drug interactions ... Potential adverse effects and drug reactions ... The medication profile will be updated as needed ... The medication profile will include both prescription and over the counter...."</p> <p>Review of an agency policy revised 7/8/19 titled "Medication Profile" stated, "... Patients receiving medications will have a current and accurate Medication Profile maintained in the medical record and the home folder. ... The comprehensive medication history will include the following: ... The Medication Profile will include: ... A list of all current patient medications, prescribed, over-the-counter (OTC) or herbal remedies ... The patient's medications are reviewed and compared to the Medication Profile during each skilled shift/visit...."</p>	G 0536	<p><i>Disclaimer: By submitting this POC the agency does not admit the allegations in the survey report or that it is 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC serve as its Credible Allegation of Compliance.</i></p> <p>The agency failed to individualize the plan of care to include all medications, supplies, and equipment and patient specific interventions.</p> <p>1. Employee F was provided education on August 13th 2020 by Clinical Supervisor as evidenced by logging in personnel file.</p> <p>Administrator educated 100% of clinical supervisors on the requirement for Home Health Certifications and Recertification for completion to include, but not be limited to, listing all medications including OTC, equipment, and supplies.</p>	09/04/2020

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	<p>During an observation of care at the home of patient #1 on 8/4/2020 at 10:07 a.m., with employee C, registered nurse (RN), and employee F, home health aide (HHA), present, clotrimazole (medication to treat fungal infection) and triple antibiotic ointment (medication to treat bacterial infection) were observed on the shelves in the patient's room.</p> <p>Clinical record review on 8/4/2020 agency documents titled "Plan of Care" for certification period 7/21/2020 - 9/18/2020 and "Patient Medication Profile" dated 8/4/2020 failed to evidence the clotrimazole and triple antibiotic ointment medications were listed as the patient's medications.</p> <p>Record review on 8/6/2020 of agency documents titled "Assessment" and "Supervisory Visit V3" dated 8/4/2020 and completed by employee C, RN, failed to evidence a medication review of clotrimazole and triple antibiotic ointment was completed.</p> <p>During an interview on 8/4/2020 at 10:28 a.m., the patient's step-father indicated the clotrimazole and triple antibiotic ointment were applied sometimes to the patient's skin.</p> <p>During an interview at the entrance conference on 8/3/2020 at 9:49 a.m., the clinical supervisor indicated when a new medication is found in the home than what is on the plan of care, the clinician is to contact the physician for a supplemental order and update the medication profile. The clinical supervisor also indicated the medication review is completed when the medication profile is updated in the electronic medical record.</p>		<p>This education was provided to all clinical supervisors during a clinical team meeting on August 27, 2020 as evidenced by the meeting agenda and signed education acknowledgement.</p> <p>2. The clinical supervisor will audit 100% of the patient Plans of care for accuracy of current medications, equipment, and supplies.</p> <p>The Administrator will review 100% recertifications weekly to ensure the patients current medication, including OTC, equipment, and supplies are updated and reflected in the documentation within 30 days.</p> <p>3. Ongoing the clinical supervisors will continue to review Plans of care for accuracy of current medications, equipment, and supplies during the recertification process</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly</p>	

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	17-14-1(a)(1)(B)		<p>basis to ensure the aide plan of care accurately reflects services ordered in the medical plan of care</p> <p>Responsible Party: Administrator</p> <p>Date of completion 9/4/2020</p> <p><i>Disclaimer:</i> <i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to ensure the comprehensive assessment accurately reflected the patient's current health, psychosocial, functional and cognitive status and failed to ensure all medications the patient was currently taking were reviewed.</p>	

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			<p>1.Employee C (Clinical Supervisor) was educated 1:1 by administrator on 8/26/2020</p> <p>Patient #1 EMR has been updated with the following effective 8/26/2020:</p> <ul style="list-style-type: none"> ·Assessment 8/4/2020- added a late logging of correction noting GT assessment missed and include detailed info. ·Logging, supplemental order for new medication profile added for medication noted during 8/4/2020 visit. ·Updated wound documentation in POC. ·Added family use of restraints and follow up with physician for supplemental order ·Family education provided regarding safe use of restraints ·New assessment and care coordination with other agency completed 8/26/2020. ·DME and safety precautions updated. ·HHA written plan of care updated. <p>The Administrator educated 100% of clinical supervisors on the requirement for assessments to reflect current health,</p>	

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			<p>psychosocial, functional and cognitive status, and review all medications and treatments for accuracy.</p> <p>This education occurred on 8/27/2020 as evidenced by meeting agenda and signed acknowledgment.</p> <p>2. The clinical supervisors will review and update as necessary 100% of the patients medication profiles for accuracy of current medications.</p> <p>The Administrator will review 100% recertification assessments weekly to ensure the patients current health, psychosocial, functional and cognitive status, and medication reconciliation, are updated and reflected in the documentation within 30 days.</p> <p>3. The clinical supervisors will continue to complete comprehensive assessment as part of the admission and recertification process.</p> <p>4. To ensure this alleged deficiency does not recur, 10 or</p>	

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G 0572 Bldg. 00	<p>484.60(a)(1) Plan of care</p> <p>Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan.</p> <p>Based on record review and interview, the agency failed to provide the services as written in the individualized plan of care in 4 of 7 clinical records reviewed. (#2, #3, #4, #6)</p> <p>The findings include:</p> <p>1. Review of an agency policy revised 4/10/2020</p>	G 0572	<p>10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure the aide plan of care accurately reflects services ordered in the medical plan of care.</p> <p>Party responsible Administrator</p> <p>Date of Completion: 9/04/2020</p> <p><i>Disclaimer: 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</i></p>	09/04/2020

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	<p>titled "Home Health Certification and Plan(s) of Care" stated, "... The Home Health Certification and Plan of Care (485) is the physician's order for home care services. ... 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(s)...."</p> <p>2. Clinical record review on 8/4/2020 for patient #2 evidenced an agency document titled "Plan of Care" for certification period 1/10/2020 - 3/9/2020 and signed by the physician, which indicated the patient was to receive skilled nursing services 4-7 days a week. The clinical record failed to evidence the patient was provided skilled nursing services for at least 4 days a week during the weeks of 1/12/2020 and 2/16/2020.</p> <p>Review of untitled agency documents dated 1/16/2020, 1/17/2020, 2/17/2020, 2/18/2020, 2/19/2020 and 2/20/2020 indicated services were canceled and stated, "... Caregiver Canceled - No Back-Fill"</p> <p>During an interview on 8/7/2020 at 9:55 a.m., the administrator indicated skilled nursing services were scheduled on 1/16/2020, 1/17/2020, 2/17/2020, 2/18/2020, 2/19/2020 and 2/20/2020 but there was not any available staff so the shifts were canceled. The administrator further indicated skilled nursing services were not provided to the patient per the plan of care.</p> <p>Record review evidenced an agency document titled "Plan of Care" for certification period 3/10/2020 - 5/8/2020 and signed by the physician on 3/5/2020, which indicated the patient was to receive skilled nursing services for 40-66 hours a week, 4-7 days a week.</p>		<p><i>compliance. The agency further reserves the right to contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to provide the services as written in the individualized plan of care.</p> <p>1. Patient #2 was discharged on May 6, 2020.</p> <p>Patient #3 was discharged on August 31, 2020</p> <p>Patient #6 was discharged on August 12, 2020</p> <p>Patients #2, 3, and 6 any additional missed shifts were faxed to the corresponding physicians and retained in medical record upon discharge.</p> <p>Patient #4 Patient #4 – clerical error was corrected on certification 3/15/2020-5/13/2020 and going forward accurately ensuring the individual needs of this client.</p>	

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	<p>Record review of an agency document titled "General Notes" dated 3/16/2020 stated, "... Advised [patient's legal guardian] that we will put services on hold until further notice" The clinical record failed to evidence a physician's order indicating services were put on hold.</p> <p>Record review of an agency document titled "Treatment/Order Update/Change in Condition" completed and signed by registered nurse on 5/8/2020 stated, "... Discharge client from Maxim Healthcare services effective 5/8/2020...." The clinical record failed to evidence skilled nursing services were provided after 3/12/2020.</p> <p>During an interview on 8/7/2020 at 9:52 a.m., the administrator indicated the patient's family did not want nursing services during the pandemic and skilled nursing services were not provided per the plan of care. The administrator indicated there was not a physician's order to place the patient's services on hold.</p> <p>3. Clinical record review on 8/4/2020 for patient #3 evidenced an agency document titled "Plan of Care" for certification period 7/3/2020 - 8/31/2020, dated and signed by the physician on 7/1/2020, which indicated the patient was to receive home health aide services for 26-42 hours a week. The clinical record failed to evidence the patient was provided home health aide services for at least 26 hours the week of 7/19/2020.</p> <p>During an interview on 8/3/2020 at 5:08 p.m., the patient indicated she has gone days without services in the past. The patient also indicated staff is not always consistent with their schedule, and sometimes the staff had to leave early or arrived late.</p>		<p>Administrator educated 100% of Clinical Supervisors on policy "Home Health Certification and Plan of Care" on the requirement the Plan of Care will be individualized to include, but not limited to, services authorized to be provided by direct care staff. Additionally, the Administrator educated all internal staff, including Clinical Supervisors, Recruiters and Field Support, on policy "Patient/Client Scheduling"</p> <p>This education was provided to all clinical supervisors during a clinical team meeting on August 27, 2020 as evidenced by the meeting agenda and signed education acknowledgement.</p> <p>This education was provided to all recruiters and field support during an office team meeting on August 27, 2020 as evidenced by signed education acknowledgement.</p> <p>.</p> <p>2. Operations Manager 100% audit of client's frequency and duration to ensure needs are being met per current schedule. Audit completed 8/27/2020. Any</p>	

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	<p>During an interview on 8/4/2020 at 1:30 p.m., the administrator indicated the agency has had difficulty staffing the patient at times due to the family dynamics in the home between the patient and the son.</p> <p>During an interview on 8/7/2020 at 10:49 a.m., the alternate administrator explained the patient was typically scheduled with the agency to receive home health aide services from 8 a.m. -11 a.m. and 2 p.m. to 5 p.m. 7 days a week. The alternate administrator further explained the patient's schedule does not typically change and any deviation to the regular schedule is most likely due to a staffing issue. The alternate administrator indicated the home health aide that typically worked the afternoon shift on the weekends had a child care issue and sometimes could not stay until 5 p.m..</p> <p>4. Clinical record review on 8/5/2020 for patient #4 evidenced an agency document titled "Plan of Care" for certification period 1/15/2020 - 3/14/2020, signed and dated by the physician on 1/8/2020, which indicated the patient was to receive home health aide services 2-3 days a week. The clinical record evidenced the patient received home health aide services 4 days a week during the week of 1/19/2020, 1/26/2020, 2/2/2020, 2/9/2020, 2/16/2020, 2/23/2020, 3/1/2020 and 3/8/2020.</p> <p>During an interview on 8/6/2020 at 3:27 p.m., the administrator indicated the plan of care ordered the patient to receive home health aide services 2-3 days a week, but the patient received services 4 days a week. The administrator indicated there was not a supplemental physician's order for the increase in frequency.</p>			<p>discrepancy /missed shifts will sent to the corresponding physician</p> <p>Ongoing, Missed shift notification sent to physician for notification of deviation from POC</p> <p>3. Ongoing, Office Leadership or Designee will be responsible for reviewing the client's 485 during the recertification process for accuracy in frequency and duration to ensure documentation accurately reflects the services provided per the individual plan of care.</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure documentation accurately reflects that the responsible party was informed of changes in frequency.</p> <p>Responsible Party: Administrator</p> <p>Date of Completion: August 27, 2020</p>

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G 0574 Bldg. 00	<p>5. Clinical record review on 8/5/2020 for patient #6 evidenced an agency document titled "Plan of Care" for certification period 5/12/2020 - 7/10/2020 signed by the physician on 5/14/2020 which indicated the patient was to receive skilled nursing services 3-5 days a week, 30-50 hours a week. The clinical record failed to evidence the patient received skilled nursing services from 6/20/2020 to 7/1/2020 and failed to evidence a physician's order putting the patient's services on hold.</p> <p>During an interview on 8/6/2020 at 10:20 a.m., the administrator indicated the family was on vacation and requested no services from 6/20/2020 to 7/1/2020. The administrator also indicated the clinical record did not contain a physician's order placing the agency's services on hold and services were not provided as ordered in the plan of care.</p> <p>6. During an interview on 8/6/2020 at 3:15 p.m., the administrator indicated the agency does not request a supplemental order from the physician to place patient's services on hold when requested by the patient or patient's family.</p> <p>17-13-1(a)</p> <p>484.60(a)(2)(i-xvi)</p> <p>Plan of care must include the following</p> <p>The individualized plan of care must include the following:</p> <ul style="list-style-type: none"> (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; 				

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	<p>(v) Prognosis;</p> <p>(vi) Rehabilitation potential;</p> <p>(vii) Functional limitations;</p> <p>(viii) Activities permitted;</p> <p>(ix) Nutritional requirements;</p> <p>(x) All medications and treatments;</p> <p>(xi) Safety measures to protect against injury;</p> <p>(xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors.</p> <p>(xiii) Patient and caregiver education and training to facilitate timely discharge;</p> <p>(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;</p> <p>(xv) Information related to any advanced directives; and</p> <p>(xvi) Any additional items the HHA or physician may choose to include.</p> <p>Based on observation, record review and interview, the agency failed to individualize the plan of care to include all medications, supplies and equipment and patient-specific interventions and education in 1 of 2 home visits conducted. (#1)</p> <p>The findings include:</p> <p>Review of an agency policy revised 4/10/2020 titled "Home Health Certification and Plan(s) of Care" stated, "... The Plan of Care shall include, but not limited to: ... Listing of all medications, including the over-the-counter ... Listing of all equipment and supplies"</p> <p>During an observation of care at the home of patient #1 on 8/4/2020 at 10:07 a.m. with employee C, registered nurse (RN), and employee F, home</p>	G 0574	<p><i>Disclaimer:</i> <i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p>	09/04/2020

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	<p>health aide (HHA), present, clotrimazole (medication to treat fungal infection) and triple antibiotic ointment (medication to treat bacterial infection) were observed on the shelves in the patient's room and an air mattress was observed under the patient in the bed. At 10:14 a.m., a tube placed into the patient's abdomen was noted. At 10:29 a.m., soft restraints were observed attached to the side rails on each side of the bed. At 10:38 a.m., 4 wounds and 1 scar were noted to the top of the patient's left hand.</p> <p>Clinical record review on 8/4/2020 for patient #1 evidenced an agency document titled "Assessment" dated 7/10/2020 which indicated the patient had a g-tube (a surgically inserted tube into the stomach through the abdomen to deliver nutrition) and received a tube feeding continuously via a feeding pump.</p> <p>Review of an agency document titled "Plan of Care" for certification period 7/21/2020 - 9/18/2020 failed to evidence the tube feeding supplies such as the feeding pump and the air mattress were included in the patient's supplies in the plan of care. The document also failed to evidence the clotrimazole and triple antibiotic ointment medications in the plan of care.</p> <p>During an interview on 8/4/2020 at 10:28 a.m., the patient's step-father indicated the clotrimazole and triple antibiotic ointment were applied sometimes to the patient's skin.</p> <p>During an interview on 8/4/2020 at 10:33 a.m., employee F, HHA, indicated she has been caring for the patient for 5 years and the restraints have been there for as long as she can remember. Employee F indicated at times the family uses the restraints when the patient bites her hand.</p>		<p>The agency failed to individualize the plan of care to include all medications, supplies, and equipment and patient specific interventions.</p> <p>1. Employee F was provided education on August 13th 2020 by Clinical Supervisor as evidenced by logging in personnel file.</p> <p>Administrator educated 100% of clinical supervisors on the requirement for Home Health Certifications and Recertification for completion to include, but not be limited to, listing all medications including OTC, equipment, and supplies.</p> <p>This education was provided to all clinical supervisors during a clinical team meeting on August 27, 2020 as evidenced by the meeting agenda and signed education acknowledgement.</p> <p>2. The clinical supervisor will audit 100% of the patient Plans of care for accuracy of current medications, equipment, and supplies.</p>	

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G 0590 Bldg. 00	<p>Employee F further indicated she does not use the restraints but per the family's direction, the home health aide explained and demonstrated how she wraps a cloth around the patient's left hand and sits next to the patient's bed and holds the patient's left hand.</p> <p>During an interview on 8/4/2020 at 10:43 a.m., employee C, RN, indicated she is aware of the wounds to the left hand and stated, "they come and go." Employee C further indicated the treatment for the wounds was for staff to protect the area on the left hand.</p> <p>During an interview on 8/6/2020 at 3:25 p.m., the clinical supervisor indicated all medications, supplies and equipment should be included on the patient's individualized plan of care. The clinical supervisor further indicated the use of restraints on the patient by the family should be included in the plan of care as well as the individualized interventions of wrapping the left hand with a cloth and holding the patient's left hand to prevent the patient from self-inflicted bite wounds.</p> <p>17-13-1(a)(1)(D)(ii, ix, x)</p> <p>484.60(c)(1) Promptly alert relevant physician of changes The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.</p>		<p>The Administrator will review 100% recertifications weekly to ensure the patients current medication, including OTC, equipment, and supplies are updated and reflected in the documentation within 30 days.</p> <p>3. Ongoing the clinical supervisors will continue to review Plans of care for accuracy of current medications, equipment, and supplies during the recertification process</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure the aide plan of care accurately reflects services ordered in the medical plan of care</p> <p>Responsible Party: Administrator</p> <p>Date of completion 9/4/2020</p>	

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	<p>Based on observation, record review and interview, the agency failed to promptly alert the physician to changes in the patient's condition or needs that suggest the plan of care should be altered in 1 of 2 home visits in a total sample of 7 clinical records reviewed. (#1)</p> <p>The findings include:</p> <p>Review of an agency policy revised 7/30/2020 titled "Ongoing Evaluation" stated, "... The Direct Care Staff shall notify the office clinical leader or clinical designee and/or physician when there is a change in the patient condition which might warrant a change in medication and/or a change to the plan of care. ... The physician will be notified to verify any changes in ... care, treatment, or services that require physician approval...."</p> <p>Review of an agency policy revised 2/16/2020 titled "Restraints" stated, "... The office clinical leader or clinical designee will contact the physician to obtain an order for the use of a restraint...."</p> <p>During an observation of care at the home of patient #1 on 8/4/2020 at 10:29 a.m., with employee C, registered nurse (RN), and employee F, home health aide (HHA), present, soft restraints were observed attached to the side rails on each side of the bed. At 10:38 a.m., 4 wounds and 1 scar were noted to the top of the patient's left hand.</p> <p>Clinical record review on 8/4/2020, for patient #1, evidenced an agency document titled "Plan of Care" for certification period 7/21/2020 - 9/18/2020, signed by the physician on 7/16/2020, which failed to evidence the family's use of restraints on the patient, behaviors exhibited by the patient and wounds to the left hand.</p>	G 0590	<p>Disclaimer: <i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to promptly alert the physician to changes in the patient's condition or needs that suggest the plan of care should be altered.</p> <p>1. Employee C (Clinical Supervisor) was educated 1:1 by administrator on 8/26/2020</p> <p>Patient #1 EMR has been updated with the following effective 8/26/2020:</p> <ul style="list-style-type: none"> ·Assessment 8/4/2020- added a late logging of correction noting 	09/04/2020

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	<p>Record review on 8/6/2020, evidenced an agency document titled "Assessment" dated 8/4/2020, and completed by employee C, RN, which stated, "... pt [patient] bites the back of her hand as part of her behaviors. skin is discolored from past injuries. ... apprx [approximately] 5 small areas of scabs noted ... HHA applies a towel around pt hand to prevent injury...." The document failed to evidence the physician was notified of the family's use of restraints on the patient and of the wounds to the left hand.</p> <p>During an interview on 8/4/2020 at 10:33 a.m., employee F, HHA, indicated she has been caring for the patient for 5 years and the restraints have been there for as long as she can remember. Employee F indicated at times the family uses the restraints when the patient bites her hand. Employee F further indicated she does not use the restraints but per the family's direction, she described and demonstrated how she wraps a cloth around the patient's left hand and sits next to the patient's bed and holds the patient's left hand when the patient bites her left hand.</p> <p>During an interview on 8/4/2020 at 10:43 a.m., employee C, RN, indicated she is aware of the wounds to the left hand and stated, "They come and go." The alternate clinical supervisor further indicated the treatment for the wounds was for the staff to protect the area on the left hand.</p> <p>During an interview on 8/6/2020 at 3:27 p.m., the clinical supervisor indicated the physician should be notified of changes in the patient's condition to include wounds, the use of restraints on the patient by the family, patient behaviors and the individualized intervention of wrapping the left hand with a cloth and holding the patient's left</p>			<p>GT assessment missed and include detailed info.</p> <ul style="list-style-type: none"> ·Logging, supplemental order for new medication profile added for medication noted during 8/4/2020 visit. ·Updated wound documentation in POC. ·Added family use of restraints and follow up with physician for supplemental order ·Family education provided regarding safe use of restraints ·New assessment and care coordination with other agency completed 8/26/2020. ·DME and safety precautions updated. ·HHA written plan of care updated. <p>Administrator educated 100% of clinical supervisors on the requirement to promptly alert the patient's physician of any changes that suggest a need to alter the plan of care.</p> <p>Education occurred on 8/27/2020 as evidenced by signed acknowledgment.</p> <p>Change in condition education was provided to Employee F by Clinical Supervisor on August 13th 2020 as evidenced by Employee F personnel file logging.</p>

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	<p>hand to prevent the patient from biting the hand. The clinical supervisor further explained even if staff was not applying restraints, the physician would be notified, an order would be obtained and the plan of care would be updated to include the use of restraints.</p> <p>17-13-1(a)(2)</p>		<p>The administrator will educate 100% of unskilled caregivers on requirement to notify the agency clinical supervisor of changes in patient condition.</p> <p>This education was provided to all direct caregivers via mailer on August 18, 2020 as evidenced by documentation of a signed, electronic, or verbal acknowledgement. This education will be completed by September 4, 2020.</p> <p>Beginning 8/19/2020 the clinical supervisors will review 100% of unskilled shift documentation weekly for compliance of change in condition notification. This audit will be completed within 30 days.</p> <p>2. The Administrator will review 100% of recertification assessments weekly for evidence that any changes to the patients care or status that could alter the current plan of care have been communicated to the patient's</p>	

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G 0606 Bldg. 00	<p>484.60(d)(3) Integrate all services Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview, the home health agency failed to integrate services with other agencies providing care to the patient to assure identification of patient needs and factors that could affect patient safety and treatment effectiveness in 1 of 1 active records receiving</p>	G 0606	<p>physician for 30 days</p> <p>3. The Administrator will continue to run change in condition report weekly to ensure all identified changes are reported per policy.</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure the aide plan of care accurately reflects services ordered in the medical plan of care. _</p> <p>Responsible Party: Administrator Date of completion 9/04/2020</p> <p><i>Disclaimer: By submitting this POC the agency does not admit the allegations in the survey report or that it the survey report or that it violated any regulations. The</i></p>	08/31/2020

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	<p>services from other agencies in a total sample of 7 clinical records reviewed. (#3)</p> <p>The findings include:</p> <p>Review of an agency policy revised 4/10/2020 titled "Care Coordination/Case Conference" stated, "... Care coordination is accomplished through communication with the members of the health care team including independent contractors where applicable. ... Interdisciplinary coordination of care is ensured through communication and case conferencing. ... Care coordination must be accomplished at least once every certification period. Evidence of the care coordination must be documented in the medical record or system of record. ... Direct Care Staff shall communicate changes in patient status amongst the assigned personnel and the office clinical leader or clinical designee. ... Direct Care Staff will communicate changes in a timely manner via telephone, one-on-one meetings, case conferences and/or home visits...."</p> <p>Clinical record review on 8/4/2020 at 1:30 p.m., for patient #3, evidenced an agency document titled "Supervisory Visit V3" dated 7/16/2020 which indicated entity C was providing services to the patient in the home. An agency document titled "Supervisory Visit V3" dated 6/29/2020, indicated entity E provided the patient with attendant care services. The clinical record failed to evidence any care coordination with entity C and E to include type and frequency of services provided.</p> <p>Review of an untitled document dated 7/2/2020, indicated the patient was lowered to the floor while ambulating to the bathroom with assistance. The document failed to evidence care coordination with the other agencies servicing the</p>		<p><i>agency is submitting this POC in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to integrate services with other agencies providing care to the patient to assure identification of patient safety and treatment effectiveness.</p> <p>1. Patient #3 was discharged on August 31, 2020. Transfer summary sent to all interdisciplinary parties including new agency.</p> <p>2. Administrator provided education to all clinical supervisors on policy "Care Coordination/Case Conference" regarding the requirement interdisciplinary coordination of care to ensure through communication at least once every certification period and upon notification of change in patient condition.</p> <p>This education was provided to all clinical supervisors during a clinical team meeting on August</p>	

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	<p>patient to inform them of the patient needing to be lowered to the floor.</p> <p>Review of an untitled document dated 7/24/2020 stated, "... Client called writer crying, wanting to know who is going to get her lunch. ... Client stated that her ATTC [attendant care provider] was at her home this morning and went to the grocery store for her but had to leave suddenly. ... Client stated that she had no one to help her. ... [writer] suggested she reach out to her waiver service provider to see if there was anything they could do to help also. ..." The document failed to evidence care coordination with the other agencies servicing the patient to inform them of the patient's needs.</p> <p>During an interview on 8/3/2020 at 5:08 p.m., the patient indicated entity D was currently providing physical therapy and had been off and on for a while. The patient further indicated entity E provided attendant care services.</p> <p>During an interview on 8/4/2020 at 3:01 p.m., the clinical supervisor indicated care coordination should occur with other agencies involved in the patient's care when there is a change in the patient status and at least every 60 days with the recertification. The clinical supervisor also indicated the agency encouraged the patient to contact entity C, who was providing physical therapy services under Medicare, to inquire about getting additional home health aide visits through entity C. When informed the patient indicated entity D was providing physical therapy services, the clinical supervisor explained she would contact entity D to inquire about what, if any, services were being provided to the patient. At 4:05 p.m., the clinical supervisor explained entity D was contacted for coordination of care, and entity</p>		<p>19, 2020 as evidenced by the meeting agenda and signed education acknowledgement.</p> <p>3. The clinical supervisor will audit 100% of their client census to ensure care coordination is completed for all interdisciplinary agencies providing care for a client at least once every certification period and upon notification of change in patient condition. This audit will be completed within 30 days.</p> <p>Ongoing, the Administrator will review 100% of recertification documentation for evidence of care coordination completed per policy.</p> <p>A form entitled "Inter-Agency Coordination of Patient Care" has been created as an additional tool for the care coordination process</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure documentation reflects care coordination is completed for all interdisciplinary</p>	

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	<p>D began physical therapy services with the patient on 7/10/2020. She also explained entity C stopped servicing the patient in March of 2020.</p> <p>During an interview on 8/7/2020 at 10:50 a.m., the clinical supervisor indicated there was no care coordination documentation in the clinical record with entity E since 3/26/2020.</p> <p>Review of an agency document titled "Patient Referral Information" dated 1/13/16, indicated the patient was receiving services from 7 a.m. - 10 a.m. and 2:30 p.m. - 5:30 p.m. daily.</p> <p>Review of an agency document titled "Plan of Care" for certification period 5/4/2020 - 7/2/2020 dated 4/25/2020 indicated the patient was to receive home health aide services 5-7 days a week, 25-42 hours a week and entity E also provided services.</p> <p>Review of an agency document titled "June 2020 Calendar for [patient #3]" evidenced the patient was not provided home health aide services for 3 hours in the afternoon on 6/2/2020, 6/3/2020, 6/4/2020, 6/6/2020, 6/7/2020, 6/9/2020, 6/13/2020, 6/14/2020, 6/17/2020, 6/20/2020, 6/21/2020, 6/27/2020, 6/28/2020 and 6/29/2020. The clinical record failed to evidence the agency coordinated care with entity E regarding patient needs.</p> <p>During an interview on 8/7/2020 at 10:53 a.m., the alternate administrator indicated the patient was typically scheduled with the agency to receive home health aide services from 8 a.m. -11 a.m. and 2 p.m. to 5 p.m. 7 days a week. The alternate administrator explained entity E provided attendant care services daily from 11 a.m. to 2 p.m.. The alternate administrator further explained</p>		<p>agencies providing care for a client at least once every certification period.</p> <p>Responsible Party: Administrator</p> <p>Date of Completion: August 31, 2020</p>	

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G 0682 Bldg. 00	<p>the agency's schedule for home health aides had to work around entity E's schedule, and if the agency's home health aides were unavailable to work the typical shift, the patient's schedule was adjusted so that not to interfere with entity E's schedule. The alternate administrator indicated he would look for documentation of coordination of care with entity E regarding the scheduling of staff to meet patient needs. At 11:50 a.m., the alternate administrator indicated he did not have any documentation of care coordination with entity E.</p> <p>17-12-2(h)</p> <p>484.70(a) Infection Prevention Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review and interview, the agency failed to follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases in 1 of 2 home visits (#1)</p> <p>The findings include: Review of agency policy titled "Hand Hygiene" revised 9/7/2016 stated "...Hand decontamination using and alcohol-based hand rub should be performed: ... After contact with a patient's/client intact skin ...After removing gloves..."</p> <p>During an observation of care at the home of</p>	G 0682	<p><i>Disclaimer:</i> <i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p>	09/04/2020

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	<p>patient #1 on 8/4/2020 at 10:10 a.m., with employee C, registered nurse (RN) and employee F, home health aide (HHA), present, employee F was observed washing patient's face with washcloth, returned washcloth to basin, and removed gloves. HHA then applied new gloves. No hand hygiene was observed before the application of new gloves. At 10:17 a.m., HHA was observed applying lotion to patient's arms and torso, removed gloves, then applied deodorant to patient. At 10:23 a.m., the HHA applied new gloves without observation of hand hygiene. At 10:24 a.m., the HHA washed the patient's genital area and buttocks, then removed gloves. The HHA then applied a diaper to patient without the use of gloves. At 10:27 a.m., the HHA applied new gloves. No hand hygiene was observed before gloves applied.</p> <p>During an interview with employee C on 8/4/2020 at 10:30 a.m., employee C indicated hand hygiene was to be performed between all glove changes and after any direct patient contact.</p> <p>17-12-1(m)</p>			<p>The agency failed to follow the accepted standards of practice, including the use of standard precautions, to prevent the transmission of infectious and communicable disease.</p> <p>1. Hand Hygiene and CDC infection control education was provided to employee F by clinical supervisor on August 13, 2020 as evidenced by employee F personnel note logging.</p> <p>2. Administrator provided education to all direct caregivers on policy "Hand Hygiene", as well as CDC regulations and guidance for infection control.</p> <p>3. This education was provided to all direct caregivers via mailer on August 18, 2020 as evidenced by a documented signed, electronic, or verbal acknowledgement. This acknowledgement will be completed by September 4, 2020.</p> <p>4. To ensure this alleged deficiency does not recur, education will be provided to all new hires during initial competency, as evidenced by the documentation on the home health</p>

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G 0686 Bldg. 00	<p>484.70(c)</p> <p>Infection control education</p> <p>Standard: Education.</p> <p>The HHA must provide infection control education to staff, patients, and caregiver(s).</p> <p>Based on record review and interview, the agency failed to provide infection control education to direct care staff.</p> <p>The findings include:</p> <p>Review of an agency policy revised 7/30/2020, titled "In-Service Program" stated, "... Annually, the office clinical leader or clinical designee will review identified educational or instructional needs for the Direct Care Staff and in collaboration with available subject matter expert(s) develop the educational plan and calendar for the upcoming year. The office clinical leader or clinical designee will: ... Ensure attendance record/sign-in sheet, course agenda, presentation, and any available handouts are</p>	G 0686	<p>aide initial and annual competency form, and quarterly self audit of 10 or 10%, whichever is greater, of the active caregiver census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure competency forms, including infection control are documented per policy.</p> <p>Responsible Party: Administrator</p> <p>Date of Completion: September 4, 2020</p> <p><i>Disclaimer:</i> <i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p>	09/04/2020

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	<p>retained in the "In-service Program" binder located in the office. ... Ensure designated staff updates the system of record with the date of participation for each employee who attended the in-service session...."</p> <p>Review of an agency document titled "COVID-19 Infectious Disease Emergency Plan" dated 3/10/2020, indicated staff would be educated on COVID-19 to include reducing spread and infection control practices.</p> <p>During an interview on 8/5/2020 at 9:31 a.m., the administrator indicated there is no documented training with direct care staff on COVID-19 to include symptoms, how it is transmitted, screening criteria and work exclusions. The administrator explained the staff has been sent emails regarding COVID-19 information, but there is no documentation of which employees were sent the information on what date. At 12:15 p.m., the administrator indicated there was no verification the staff received and understood the information but was working on getting a confirmation that emails were opened. No additional documentation was provided.</p>		<p>The agency failed to provide infection control education to direct care staff.</p> <p>1.BEGINNING 3/10/2020 the following education was sent. (attached is examples of education provided).</p> <ul style="list-style-type: none"> ·Guidelines for Bandanas and Cloth Mask ·Self Assessment Check in procedure ·Free Self Care and Education Courses ·COVID19 Keeping your patients safe ·COVID19 Travel Alert ·New Daily Self Check in Questions ·COVID updates ·Important patient Pre Screening Instructions for COVID ·Updated Guidelines on Face Masks and Coverings. <p>Administrator again provided education to all direct caregivers related to COVID 19 including but not limited to, symptoms, how it is transmitted, screening criteria, work exclusion and use of PPE per Maxim Healthcare Services and CDC guidelines.</p>	

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

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			<p>2. Ongoing effective 8/21/2020 the Field Support Manager to review 100% of new hire competencies for completion and accuracy.</p> <p>This COVID 19 education to all direct caregivers was provided via mailer on August 18, 2020 as evidenced by a documented signed, electronic, or verbal acknowledgement. This education will be completed by September 4, 2020.</p> <p>3. Field Support team will continue review all new hires during initial competency, as evidenced by the documentation on the home health aide initial competency form.</p> <p>4. To ensure this alleged deficiency does not recur 10 or 10%, whichever is greater, of the active caregiver census will be reviewed by the Field Support Manager on a quarterly basis to ensure competency forms, including infection control are documented per policy.</p> <p>Responsible Party: Administrator</p> <p>Date of Completion: September 4, 2020</p>	

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NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP COD 5265 COMMERCE DRIVE, STE E CROWN POINT, IN 46307		
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G 0798 Bldg. 00	<p>484.80(g)(1) Home health aide assignments and duties Standard: Home health aide assignments and duties.</p> <p>Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist).</p> <p>Based on observation, record review and interview, the agency failed to assign the home health aide to patients with written patient care instructions in 1 of 1 home visits with the home health aide in a total sample of 7 clinical records reviewed. (#1)</p> <p>The findings include:</p> <p>Review of an agency policy revised 7/8/19, titled "Home Health Aide Plan of Care" stated, "... The Home Health Aide Plan of Care (HHA POC) will be individualized to the specific patient and will include at least: ... Type of services/procedures to be provided ... Specific procedure(s) to be performed, including amount, frequency and duration ... Safety measures, including specific equipment ... Each patient receiving home health aide services will have an individualized plan developed by the Registered Nurse ... The developed HHA POC is to be utilized to direct care performed by the assigned aide. ... Home Health Aide shall not make any modifications in the care they are instructed to provide except by</p>	G 0798	<p><i>Disclaimer: By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to assign the home health aide to patients with written patient care instructions.</p>	09/04/2020

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	<p>the written updates to the HHA POC as modified by the Professional.... The HHA POC will be reviewed at least every 60 days as a component of the recertification comprehensive assessment. If there are no changes to the HHA POC, the Professional shall document the review on the supervisory visit form. If there are significant changes to the HHA POC, the Professional shall complete a new HHA POC form which reflects the changes clearly described.... "</p> <p>During an observation of care at the home of patient #1 on 8/4/2020 at 10:29 a.m., with employee C, registered nurse (RN), and employee F, home health aide (HHA), present, soft restraints were observed attached to the side rails on each side of the bed.</p> <p>Clinical record review on 8/4/2020 for patient #1, evidenced an agency document titled "Aide - Care Plan" last reviewed and signed by the RN on 5/2/18 which failed to evidence written instructions on how the home health aide was to provide protection to the patient when the patient demonstrated behaviors to include attempts to bite herself.</p> <p>Record review on 8/6/2020, evidenced an agency document titled "Assessment" dated 8/4/2020, and completed by employee C, RN, which stated, "... pt [patient] bites the back of her hand as part of her behaviors. skin is discolored from past injuries. ... apprx [approximately] 5 small areas of scabs noted ... HHA applies a towel around pt hand to prevent injury...." This document failed to evidence changes were made to the home health aide plan of care to include directions for the home health aide to apply a towel to the patient's hand to prevent injury when the patient attempted to bite herself.</p>		<p>1. Patient #1 EMR updated including Written HHA care plan</p> <p>2. 1:1 education with Employee C (Clinical Supervisor) occurred 8/26/2020 provided by Administrator</p> <p>Administrator educated 100% of clinical supervisors on the requirement for a Skilled Nurse to develop and update an aide plan of care for all patients receiving home health aide services to ensure the aide plan of care accurately reflects services ordered on the medical plan of care</p> <p>This education occurred 8/27/2020 as evidenced by signed acknowledgement</p> <p>3. The Clinical Supervisors will review 100% of HHA care plans and ensure they have had a competency evaluation on all tasks ordered by 9/4/2020.</p> <p>The administrator will review 100% of recertification documentation weekly for compliance; including care coordination completed and the updated aide care plan accurately reflects the medical plan of care. This audit will be</p>	

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	<p>Record review on 8/6/2020, evidenced an agency document titled "Supervisory Visit V3 dated 8/4/2020 and completed by employee C, RN, which failed to evidence changes were made to the home health aide plan of care to include directions for the home health aide to apply a towel to the patient's hand to prevent injury when the patient attempted to bite herself.</p> <p>During an interview on 8/4/2020 at 10:29 a.m., employee F, HHA, explained and demonstrated how she wraps a cloth around the patient's left hand and sits next to the patient's bed and holds the patient's left hand to prevent the patient from biting herself.</p> <p>During an interview on 8/4/2020 at 10:43 a.m., employee C, RN, indicated the treatment for the wounds on the patient's left hand was for staff to protect the area when the patient attempted to bite herself.</p> <p>During an interview on 8/6/2020 at 5:06 p.m., the clinical supervisor indicated the registered nurse should update the home health aide plan of care to include patient-specific interventions the staff is to provide to prevent the patient from biting her hand.</p> <p>17-14-1(m)</p>		<p>completed within 30 days.</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure the aide plan of care accurately reflects services ordered in the medical plan of care.</p> <p>Responsible Party: Administrator</p> <p>Date of completion 9/04/2020</p> <p><i>Disclaimer:</i></p> <p><i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to report changes in the patient's</p>	

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			<p>condition to a registered nurse or other appropriate skilled professional.</p> <p>1. Patient #1 EMR including written HHA plan of care updated.</p> <p>This education was provided to employee F by clinical supervisor on August 13, 2020 as evidenced by employee F personnel note logging.</p> <p>2. The administrator will educate 100% of unskilled caregivers on requirement to notify the agency clinical supervisor of changes in patient condition.</p> <p>This education was provided to all direct caregivers via mailer on August 18, 2020 as evidenced by documentation of a signed, electronic, or verbal acknowledgement. This education will be completed by September 4, 2020.</p> <p>Beginning 8/19/2020 the clinical supervisors will review 100% of unskilled shift documentation weekly for compliance of change in condition notification. This audit will be completed within 30 days.</p>	

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

PRINTED: 09/08/2020

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157679	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 08/07/2020
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G 0800 Bldg. 00	<p>484.80(g)(2)</p> <p>Services provided by HH aide</p> <p>A home health aide provides services that are:</p> <ul style="list-style-type: none"> (i) Ordered by the physician; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide 		<p>3. The Administrator will run the change in condition report weekly to ensure all changes to patient status are identified and reported per policy</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure that changes in condition are reported per policy.</p> <p>Responsible Party: Administrator</p> <p>Date of completion 9/04/2020</p>	

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	<p>training.</p> <p>Based on observation, record review and interview, the home health aide provided services that were not included in the plan of care in 1 of 1 home visits with a home health aide in a total sample of 7 clinical records reviewed. (#1)</p> <p>The findings include:</p> <p>Review of an agency policy revised 7/8/19 titled "Home Health Aide Plan of Care" stated, "... The Home Health Aide Plan of Care (HHA POC) will be individualized to the specific patient and will include at least: ... Type of services/procedures to be provided ... Specific procedure(s) to be performed, including amount, frequency and duration ... Each patient receiving home health aide services will have an individualized plan developed by the Registered Nurse ... The developed HHA POC is to be utilized to direct care performed by the assigned aide. ... Home Health Aide shall not make any modifications in the care they are instructed to provide except by the written updates to the HHA POC as modified by the Professional...."</p> <p>During an observation of care at the home of patient #1 on 8/4/2020 at 10:29 a.m., with employee C, registered nurse (RN), and employee F, home health aide (HHA) present, the HHA was observed applying an ointment to the buttocks.</p> <p>Clinical record review on 8/4/2020 for patient #1, evidenced an agency document titled "Aide - Care Plan" last reviewed and signed by the RN on 5/2/18, which failed to evidence written instructions for the home health aide to apply ointments to the patient's skin.</p> <p>During an interview on 8/4/2020 at 10:29 a.m.,</p>	G 0800	<p><i>Disclaimer:</i> <i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to provide the services as written in the individualized plan of care.</p> <p>1. Patient #2 was discharged on May 6, 2020.</p> <p>Patient #3 was discharged on August 31, 2020</p> <p>Patient #6 was discharged on August 12, 2020</p> <p>Patients #2,3, and 6 any additional missed shifts were</p>	08/27/2020

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	<p>employee F, HHA, indicated she was applying Vaseline (skin protectant) to the patient's buttocks.</p> <p>During an interview on 8/6/2020 at 5:06 p.m., the clinical supervisor indicated the home health aide plan of care should be updated to include written instructions for the home health aide to apply Vaseline.</p>		<p>faxed to the corresponding physicians and retained in medical record upon discharge.</p> <p>Patient #4 Patient #4 – clerical error was corrected on certification 3/15/2020-5/13/2020 and going forward accurately ensuring the individual needs of this client.</p> <p>Administrator educated 100% of Clinical Supervisors on policy "Home Health Certification and Plan of Care" on the requirement the Plan of Care will be individualized to include, but not limited to, services authorized to be provided by direct care staff. Additionally, the Administrator educated all internal staff, including Clinical Supervisors, Recruiters and Field Support, on policy "Patient/Client Scheduling"</p> <p>This education was provided to all clinical supervisors during a clinical team meeting on August 27, 2020 as evidenced by the meeting agenda and signed education acknowledgement.</p> <p>This education was provided to all</p>	

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				<p>recruiters and field support during an office team meeting on August 27, 2020 as evidenced by signed education acknowledgement.</p> <p>.</p> <p>2. Operations Manager 100% audit of client's frequency and duration to ensure needs are being met per current schedule. Audit completed 8/27/2020. Any discrepancy /missed shifts will be sent to the corresponding physician</p> <p>Ongoing, Missed shift notification sent to physician for notification of deviation from POC</p> <p>3. Ongoing, Office Leadership or Designee will be responsible for reviewing the client's 485 during the recertification process for accuracy in frequency and duration to ensure documentation accurately reflects the services provided per the individual plan of care.</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure documentation accurately reflects that the</p>

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G 0804 Bldg. 00	<p>484.80(g)(4) Aides are members of interdisciplinary team Home health aides must be members of the interdisciplinary team, must report changes in the patient's condition to a registered nurse or other appropriate skilled professional, and must complete appropriate records in compliance with the HHA's policies and procedures.</p> <p>Based on observation, record review and interview, the home health aide failed to report changes in the patient's condition to a registered nurse or other appropriate skilled professional in 2 of 4 records reviewed with home health aide services in a total sample of 7 clinical records reviewed. (#1, #5)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of an agency policy revised 4/10/2020 titled "Care Coordination/Case Conference" stated, "... Care coordination is accomplished through communication with the members of the health care team ... Interdisciplinary coordination of care is ensured through communication and case conferencing. ... Evidence of the care coordination must be documented in the medical record or system of record. ... Direct Care Staff 	G 0804	<p>responsible party was informed of changes in frequency.</p> <p>Responsible Party: Administrator</p> <p>Date of Completion: August 27, 2020</p> <p><i>Disclaimer:</i> <i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p>	09/04/2020

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	<p>shall communicate changes in patient status amongst the assigned personnel and the office clinical leader or clinical designee. ... Direct Care Staff will communicate changes in a timely manner via telephone, one-on-one meetings, case conferences and/or home visits...."</p> <p>2. During an observation of care at the home of patient #1, on 8/4/2020 at 10:29 a.m., with employee C, registered nurse (RN), and employee F, home health aide (HHA) present, soft restraints were observed attached to the side rails on each side of the bed.</p> <p>Clinical record review on 8/4/2020, for patient #1, evidenced an agency document titled "Plan of Care" for certification period 7/21/2020 - 9/18/2020 and agency documents titled "Assessment" dated 6/10/2020 and 7/10/2020 which failed to evidence the family's use of restraints on the patient.</p> <p>During an interview on 8/4/2020 at 10:33 a.m., employee F, HHA, indicated she has been caring for the patient for 5 years and the restraints have been there for as long as she can remember. Employee F indicated at times the family uses the restraints when the patient bites her hand.</p> <p>During an interview on 8/4/2020 at 10:43 a.m., employee C, RN, indicated she was not aware of the restraints.</p> <p>During an interview on 8/6/2020 at 3:31 p.m., the clinical supervisor indicated the home health aide should inform the RN case manager of the family's use of restraints on the patient. The clinical supervisor further explained even if staff was not applying restraints, the physician would be notified, an order would be obtained and the plan of care would be updated to include the use of</p>		<p>The agency failed to report changes in the patient's condition to a registered nurse or other appropriate skilled professional.</p> <p>1. Patient #1 EMR including written HHA plan of care updated.</p> <p>This education was provided to employee F by clinical supervisor on August 13, 2020 as evidenced by employee F personnel note logging.</p> <p>2. The administrator will educate 100% of unskilled caregivers on requirement to notify the agency clinical supervisor of changes in patient condition.</p> <p>This education was provided to all direct caregivers via mailer on August 18, 2020 as evidenced by documentation of a signed, electronic, or verbal acknowledgement. This education will be completed by September 4, 2020.</p> <p>Beginning 8/19/2020 the clinical supervisors will review 100% of unskilled shift documentation weekly for compliance of change</p>	

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G 0942 Bldg. 00	<p>restraints.</p> <p>3. Clinical record review on 8/5/2020, for patient #5, evidenced a document labeled "Aide Weekly Note" dated 9/26/2016 and 9/27/2016 on which employee G, home health aide (HHA), indicated patient #5 complained of pain in legs and catheter. Clinical record review failed to show evidence of communication from employee G to clinical supervisor regarding patient's pain.</p> <p>During an interview on 8/7/2020 at 9:38 a.m., employee A, clinical manager, indicated the HHA is to notify clinical supervisor if patient has pain or any change in condition and a coordination note should be made documenting communication.</p> <p>484.105(a) Governing body Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment</p>		<p>in condition notification. This audit will be completed within 30 days.</p> <p>3. The Administrator will run the change in condition report weekly to ensure all changes to patient status are identified and reported per policy</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure that changes in condition are reported per policy.</p> <p>Responsible Party: Administrator</p> <p>Date of completion 9/04/2020</p>	

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	<p>and performance improvement program. Based on record review and interview, the governing body failed to assume responsibility of the agency's personnel records and criminal background screening.</p> <p>The findings include:</p> <p>Review of an agency policy revised 12/3/17 titled "Governing Body" stated, "... The business is directed by the Governing Body which assumes full legal authority and responsibility for the office's overall management and operation ... The office administrator or designee shall: ... Organize and direct ongoing office functions"</p> <p>During an interview on 8/5/2020 at 4:22 p.m., employee D indicated the employee's file should be complete at the agency and entity A receives and maintains the employee's results for the criminal background checks for the agency's office staff. Employee D indicated entity A tracks and emails office employees every 3 years when a new background check is to be completed. Employee D indicated entity A receives the background results and the agency only receives the results if the agency requests the results from entity A. Employee D indicated entity A changed the process of the results of the criminal background check of the agency's office staff to be maintained by entity A a while back.</p> <p>During an interview on 8/6/2020 at 2:40 p.m., the administrator indicated entity A is not a part of agency staff but offers corporate support. When asked to explain how the agency's governing body maintains the responsibility of the personnel records in regards to the criminal background check of the office staff, the administrator stated, "I see what you mean."</p>	G 0942	<p><i>Disclaimer:</i> <i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The Governing Body failed to assume responsibility of the agency's personnel records and criminal background screening.</p> <p>1. The agency has met this requirement by following the agency's policy HR_Background Checks_004.</p> <p>5.9.2. For Team Members (internal employees), a copy of the criminal background reports will be maintained electronically by Headquarters. Updated background checks will be made available to the local office upon</p>	09/04/2020

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	17-12-1(b)		<p>request in the event of an audit. Any background checks on Team Members that are stored in the office personnel file should be kept in a locked drawer in the office leader's desk where they can only be accessed by that office leader.</p> <p>5.2.6. EveryThreeYears (Triennial) Background Checks</p> <p>5.2.6.1. Triennially, the assigned office personnel shall conduct the following background checks of employees, independent contractors, interns, temporary employees and volunteers. For team members (internal employees) these three year checks will be initiated by the Background Investigations Team. Results are stored electronically and will be made available to the local office upon request for auditing purposes.</p> <p>2. The Administrator or designee will continue to track requirements of all staff. As requested office leadership will obtain a copy of the background checks from the Backgrounds team at headquarters.</p> <p>3. The Field Support Manager ensured 100% of internal employees had current and DOH backgrounds. Please see the attached background for employee E, found to be in compliance with the agency's policy.</p>	

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G 1028 Bldg. 00	<p>484.110(d) Protection of records Standard: Protection of records. The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164.</p> <p>Based on observation, record review and interview, the agency failed to safeguard the clinical record, its contents and the information contained therein from loss or unauthorized use.</p> <p>The findings include:</p> <p>Review of an agency policy dated 1/1/15 titled "Maxim Information Security Policy" stated, "... All Company Personnel are responsible for keeping Company Information, especially Protected Information, protected from loss and from unauthorized access, modification, destruction, or disclosure...."</p>	G 1028	<p>4. To ensure this alleged deficiency does not recur 10 or 10%, whichever is greater, of the active caregiver census will be reviewed by the Field Support Manager on a quarterly basis to ensure background forms are completed per policy.</p> <p>Responsible Party: Administrator</p> <p>Date of Completion: September 4, 2020</p>	09/04/2020

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	<p>At time of entrance to the agency on 8/3/2020 at 9:45 a.m., an envelope addressed to the office of person B was observed unsecured on top of a mailbox outside of the entrance door to the agency. A sticky note was attached to the envelope which stated, "Outgoing Please pick up Thank you ..."</p> <p>Review of an agency document on 8/3/2020 at 10:45 a.m. inside an envelope addressed to person B evidenced a letter to patient #3 which indicated the patient was being discharged from the agency and stated, "... you would benefit from a higher level of care, which cannot be provided by our offices...." This document also indicated the patient's first and last name, her address and the name of her primary care physician.</p> <p>During an interview on 8/3/2020 at 10:45 a.m., the administrator indicated in the envelope was a copy of the discharge notice from the clinical record for patient #3 which was being mailed to the physician and placed on top of the mailbox outside for the mail carrier to pick-up. The administrator indicated the usual protocol was to place outgoing in the tray on top of the receptionist's desk inside to keep the patient's information protected.</p> <p>17-15-1(c)</p>		<p><i>as its Credible Allegation of Compliance.</i></p> <p>The agency failed to safeguard the clinical record, its contents and the information contained therein from loss or unauthorized use.</p> <p>1. Field Support Manager provided 1:1 education to person responsible for outgoing mail on 8/14/2020. Education evidenced by personnel logging.</p> <p>2. Administrator reeducated 100% of internal team members on the Maxim Information Security Policy. Education to office team occurred 8/20/2020. As evidenced by signed acknowledgment.</p> <p>3. Going forward all outgoing mail, including protected information will be secured within the office at all times.</p> <p>4. To ensure alleged deficiency does not reoccur the Administrator will ensure all HIPAA practices are followed throughout the branch during quarterly self auditing process.</p>	

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

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N 0000 Bldg. 00	<p>This visit was a Complaint / Federal Focused Infection Control Survey.</p> <p>Complaint:</p> <p>IN00211469 - substantiated with related and unrelated findings IN00291962 - substantiated with related and unrelated findings IN00295964 - substantiated with related and unrelated findings</p> <p>Survey Dates: 8/3/2020 - 8/7/2020</p> <p>Facility: IN004862</p> <p>Unduplicated Census: 80</p> <p>Current Census: 80</p> <p>Sample Selection:</p> <p>Home Visits: 2 Total clinical records reviewed: 7</p>	N 0000	<p>Responsible Party: Administrator</p> <p>Date of completion 9/04/2020</p>	
N 0442 Bldg. 00	410 IAC 17-12-1(b) Home health agency administration/management Rule 12 Sec. 1(b) A governing body, or			

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	<p>designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following:</p> <p>(1) Appoint a qualified administrator.</p> <p>(2) Adopt and periodically review written bylaws or an acceptable equivalent.</p> <p>(3) Oversee the management and fiscal affairs of the home health agency.</p> <p>Based on record review and interview, the governing body failed to assume responsibility of the agency's personnel records and criminal background screening.</p> <p>The findings include:</p> <p>Review of an agency policy revised 12/3/17 titled "Governing Body" stated, "... The business is directed by the Governing Body which assumes full legal authority and responsibility for the office's overall management and operation ... The office administrator or designee shall: ... Organize and direct ongoing office functions"</p> <p>During an interview on 8/5/2020 at 4:22 p.m., employee D indicated the employee's file should be complete at the agency and entity A receives and maintains the employee's results for the criminal background checks for the agency's office staff. Employee D indicated entity A tracks and emails office employees every 3 years when a new background check is to be completed. Employee D indicated entity A receives the background results and the agency only receives the results if the agency requests the results from entity A. Employee D indicated entity A changed the process of the results of the criminal background check of the agency's office staff to be maintained by entity A a while back.</p>	N 0442	<p><i>Disclaimer:</i></p> <p><i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The Governing Body failed to assume responsibility of the agency's personnel records and criminal background screening.</p> <p>1. The agency has met this requirement by following the agency's policy HR_Background Checks_004.</p>	09/04/2020

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	<p>During an interview on 8/6/2020 at 2:40 p.m., the administrator indicated entity A is not a part of agency staff but offers corporate support. When asked to explain how the agency's governing body maintains the responsibility of the personnel records in regards to the criminal background check of the office staff, the administrator stated, "I see what you mean."</p>			<p>5.9.2. For Team Members (internal employees), a copy of the criminal background reports will be maintained electronically by Headquarters. Updated background checks will be made available to the local office upon request in the event of an audit. Any background checks on Team Members that are stored in the office personnel file should be kept in a locked drawer in the office leader's desk where they can only be accessed by that office leader.</p> <p>5.2.6. EveryThreeYears (Triennial) Background Checks 5.2.6.1. Triennially, the assigned office personnel shall conduct the following background checks of employees, independent contractors, interns, temporary employees and volunteers. For team members (internal employees) these three year checks will be initiated by the Background Investigations Team. Results are stored electronically and will be made available to the local office upon request for auditing purposes.</p> <p>2. The Administrator or designee will continue to track requirements of all staff. As requested office leadership will obtain a copy of the background checks from the Backgrounds team at headquarters.</p>

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N 0446 Bldg. 00	<p>410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3)</p> <p>Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following:</p> <p>(3) Employ qualified personnel and ensure adequate staff education and evaluations.</p> <p>Based on record review and interview, the agency</p>	N 0446	<p>3. The Field Support Manager ensured 100% of internal employees had current and DOH backgrounds. Please see the attached background for employee E, found to be in compliance with the agency's policy.</p> <p>4. To ensure this alleged deficiency does not recur 10 or 10%, whichever is greater, of the active caregiver census will be reviewed by the Field Support Manager on a quarterly basis to ensure background forms are completed per policy.</p> <p>Responsible Party: Administrator</p> <p>Date of Completion: September 4, 2020</p> <p><i>Disclaimer:</i></p>	09/04/2020

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	<p>failed to provide infection control education to direct care staff.</p> <p>The findings include:</p> <p>Review of an agency policy revised 7/30/2020, titled "In-Service Program" stated, "... Annually, the office clinical leader or clinical designee will review identified educational or instructional needs for the Direct Care Staff and in collaboration with available subject matter expert(s) develop the educational plan and calendar for the upcoming year. The office clinical leader or clinical designee will: ... Ensure attendance record/sign-in sheet, course agenda, presentation, and any available handouts are retained in the "In-service Program" binder located in the office. ... Ensure designated staff updates the system of record with the date of participation for each employee who attended the in-service session...."</p> <p>Review of an agency document titled "COVID-19 Infectious Disease Emergency Plan" dated 3/10/2020, indicated staff would be educated on COVID-19 to include reducing spread and infection control practices.</p> <p>During an interview on 8/5/2020 at 9:31 a.m., the administrator indicated there is no documented training with direct care staff on COVID-19 to include symptoms, how it is transmitted, screening criteria and work exclusions. The administrator explained the staff has been sent emails regarding COVID-19 information, but there is no documentation of which employees were sent the information on what date. At 12:15 p.m., the administrator indicated there was no verification the staff received and understood the information but was working on getting a</p>		<p><i>By submitting this POC the agency does not admit the allegations in the survey report or that it is 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to provide infection control education to direct care staff.</p> <p>1. Beginning 3/10/2020 the following education was sent. (attached is examples of education provided).</p> <ul style="list-style-type: none"> · Guidelines for Bandanas and Cloth Mask · Self Assessment Check in procedure · Free Self Care and Education Courses · COVID19 Keeping your patients safe · COVID19 Travel Alert · New Daily Self Check in Questions · COVID updates · Important patient Pre Screening 	

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	confirmation that emails were opened. No additional documentation was provided.		<p>Instructions for COVID</p> <ul style="list-style-type: none"> ·Updated Guidelines on Face Masks and Coverings. <p>Administrator again provided education to all direct caregivers related to COVID 19 including but not limited to, symptoms, how it is transmitted, screening criteria, work exclusion and use of PPE per Maxim Healthcare Services and CDC guidelines.</p> <p>2. Ongoing effective 8/21/2020 the Field Support Manager to review 100% of new hire competencies for completion and accuracy.</p> <p>This COVID 19 education to all direct caregivers was provided via mailer on August 18, 2020 as evidenced by a documented signed, electronic, or verbal acknowledgement. This education will be completed by September 4, 2020.</p> <p>3. Field Support team will continue review all new hires during initial competency, as evidenced by the documentation on the home health aide initial competency form.</p> <p>4. To ensure this alleged</p>	

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N 0458 Bldg. 00	<p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:</p> <ul style="list-style-type: none"> (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. <p>Based on record review and interview, the home</p>	N 0458	<p>deficiency does not recur 10 or 10%, whichever is greater, of the active caregiver census will be reviewed by the Field Support Manager on a quarterly basis to ensure competency forms, including infection control are documented per policy.</p> <p>Responsible Party: Administrator</p> <p>Date of Completion: September 4, 2020</p>	09/04/2020

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	<p>health agency failed to ensure personnel records included documentation of the criminal background check in 1 of 5 clinical office staff personnel records reviewed. (E)</p> <p>The findings include:</p> <p>Review of an agency policy revised 7/8/19 titled "Hiring of Internal Personnel - Clinical" stated, "... Within three (3) days of the start of employment, the following documents must be returned to Talent Resources for placement in the employees personnel file: ... Any other forms ... pertaining to state specific requirements. ..."</p> <p>Personnel record review on 8/5/2020 for employee E, registered nurse (RN), date of hire 10/1/19 and first patient contact date 10/30/19, failed to evidence a criminal background check.</p> <p>During an interview on 8/5/2020 at 4:34 p.m., employee D indicated the agency did not have a copy of the criminal background check for employee E. Employee D indicated she would need to request a copy of the criminal background check for employee D from entity A.</p> <p>During an interview on 8/6/2020 at 2:40 p.m., the administrator indicated all employees should have a copy of the criminal background check in their employee file maintained at the agency.</p>		<p><i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The Governing Body failed to assume responsibility of the agency's personnel records and criminal background screening.</p> <p>1. The agency has met this requirement by following the agency's policy HR_Background Checks_004.</p> <p>5.9.2. For Team Members (internal employees), a copy of the criminal background reports will be maintained electronically by Headquarters. Updated background checks will be made available to the local office upon</p>	

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			<p>request in the event of an audit. Any background checks on Team Members that are stored in the office personnel file should be kept in a locked drawer in the office leader's desk where they can only be accessed by that office leader.</p> <p>5.2.6. EveryThreeYears (Triennial) Background Checks 5.2.6.1. Triennially, the assigned office personnel shall conduct the following background checks of employees, independent contractors, interns, temporary employees and volunteers. For team members (internal employees) these three year checks will be initiated by the Background Investigations Team. Results are stored electronically and will be made available to the local office upon request for auditing purposes. The following background reports must be requested as early in the month as possible and no later than the last day of the anniversary month of completion</p> <p>2. The Administrator or designee will continue to track requirements of all staff. As requested office leadership will obtain a copy of the background checks from the Backgrounds team at headquarters.</p> <p>3. The Field Support Manager ensured 100% of internal</p>	

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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, record review and interview, the agency failed to follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases in 1 of 2</p>	N 0470	<p>employees had current and DOH backgrounds. Please see the attached background for employee E, found to be in compliance with the agency's policy.</p> <p>4. To ensure this alleged deficiency does not recur 10 or 10%, whichever is greater, of the active caregiver census will be reviewed by the Field Support Manager on a quarterly basis to ensure background checks are completed per policy.</p> <p>Responsible Party: Administrator Date of Completion: September 4, 2020</p> <p><i>Disclaimer:</i> <i>By submitting this POC the agency does not admit the allegations in the survey report or that it the survey report or that it</i></p>	09/04/2020

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	<p>home visits (#1)</p> <p>The findings include:</p> <p>Review of agency policy titled "Hand Hygiene" revised 9/7/2016 stated "...Hand decontamination using and alcohol-based hand rub should be performed: ... After contact with a patient's/client intact skin ...After removing gloves...."</p> <p>During an observation of care at the home of patient #1 on 8/4/2020 at 10:10 a.m., with employee C, registered nurse (RN) and employee F, home health aide (HHA), present, employee F was observed washing patient's face with washcloth, returned washcloth to basin, and removed gloves. HHA then applied new gloves. No hand hygiene was observed before the application of new gloves. At 10:17 a.m., HHA was observed applying lotion to patient's arms and torso, removed gloves, then applied deodorant to patient. At 10:23 a.m., the HHA applied new gloves without observation of hand hygiene. At 10:24 a.m., the HHA washed the patient's genital area and buttocks, then removed gloves. The HHA then applied a diaper to patient without the use of gloves. At 10:27 a.m., the HHA applied new gloves. No hand hygiene was observed before gloves applied.</p> <p>During an interview with employee C on 8/4/2020 at 10:30 a.m., employee C indicated hand hygiene was to be performed between all glove changes and after any direct patient contact.</p>		<p><i>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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to follow the accepted standards of practice, including the use of standard precautions, to prevent the transmission of infectious and communicable disease.</p> <p>1. Hand Hygiene and CDC infection control education was provided to employee F by clinical supervisor on August 13, 2020 as evidenced by employee F personnel note logging.</p> <p>2. Administrator provided education to all direct caregivers on policy "Hand Hygiene", as well as CDC regulations and guidance for infection control.</p> <p>3. This education was provided to all direct caregivers via mailer on August 18, 2020 as evidenced by</p>	

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N 0486 Bldg. 00	410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on record review and interview, the home health agency failed to integrate services with other agencies providing care to the patient to	N 0486	<p>a documented signed, electronic, or verbal acknowledgement. This a acknowledgement will be completed by September 4, 2020.</p> <p>4. To ensure this alleged deficiency does not recur, education will be provided to all new hires during initial competency, as evidenced by the documentation on the home health aide initial and annual competency form, and quarterly self audit of 10 or 10%, whichever is greater, of the active caregiver census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure competency forms, including infection control are documented per policy.</p> <p>Responsible Party: Administrator Date of Completion: September 4, 2020</p> <p><i>Disclaimer:</i> <i>By submitting this POC the agency does not admit the</i></p>	08/31/2020

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	<p>assure identification of patient needs and factors that could affect patient safety and treatment effectiveness in 1 of 1 active records receiving services from other agencies in a total sample of 7 clinical records reviewed. (#3)</p> <p>The findings include:</p> <p>Review of an agency policy revised 4/10/2020 titled "Care Coordination/Case Conference" stated, "... Care coordination is accomplished through communication with the members of the health care team including independent contractors where applicable. ... Interdisciplinary coordination of care is ensured through communication and case conferencing. ... Care coordination must be accomplished at least once every certification period. Evidence of the care coordination must be documented in the medical record or system of record. ... Direct Care Staff shall communicate changes in patient status amongst the assigned personnel and the office clinical leader or clinical designee. ... Direct Care Staff will communicate changes in a timely manner via telephone, one-on-one meetings, case conferences and/or home visits...."</p> <p>Clinical record review on 8/4/2020 at 1:30 p.m., for patient #3, evidenced an agency document titled "Supervisory Visit V3" dated 7/16/2020 which indicated entity C was providing services to the patient in the home. An agency document titled "Supervisory Visit V3" dated 6/29/2020, indicated entity E provided the patient with attendant care services. The clinical record failed to evidence any care coordination with entity C and E to include type and frequency of services provided.</p> <p>Review of an untitled document dated 7/2/2020, indicated the patient was lowered to the floor</p>		<p><i>allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to integrate services with other agencies providing care to the patient to assure identification of patient safety and treatment effectiveness.</p> <p>1. Patient #3 was discharged on August 31, 2020. Transfer summary sent to all interdisciplinary parties including new agency.</p> <p>2. Administrator provided education to all clinical supervisors on policy "Care Coordination/Case Conference" regarding the requirement interdisciplinary coordination of care to ensure through communication at least once every certification period and upon notification of change in patient condition.</p>	

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	<p>while ambulating to the bathroom with assistance. The document failed to evidence care coordination with the other agencies servicing the patient to inform them of the patient needing to be lowered to the floor.</p> <p>Review of an untitled document dated 7/24/2020 stated, "... Client called writer crying, wanting to know who is going to get her lunch. ... Client stated that her ATTC [attendant care provider] was at her home this morning and went to the grocery store for her but had to leave suddenly. ... Client stated that she had no one to help her. ... [writer] suggested she reach out to her waiver service provider to see if there was anything they could do to help also. ..." The document failed to evidence care coordination with the other agencies servicing the patient to inform them of the patient's needs.</p> <p>During an interview on 8/3/2020 at 5:08 p.m., the patient indicated entity D was currently providing physical therapy and had been off and on for a while. The patient further indicated entity E provided attendant care services.</p> <p>During an interview on 8/4/2020 at 3:01 p.m., the clinical supervisor indicated care coordination should occur with other agencies involved in the patient's care when there is a change in the patient status and at least every 60 days with the recertification. The clinical supervisor also indicated the agency encouraged the patient to contact entity C, who was providing physical therapy services under Medicare, to inquire about getting additional home health aide visits through entity C. When informed the patient indicated entity D was providing physical therapy services, the clinical supervisor explained she would contact entity D to inquire about what, if any,</p>		<p>This education was provided to all clinical supervisors during a clinical team meeting on August 19, 2020 as evidenced by the meeting agenda and signed education acknowledgement.</p> <p>3. The clinical supervisor will audit 100% of their client census to ensure care coordination is completed for all interdisciplinary agencies providing care for a client at least once every certification period and upon notification of change in patient condition. This audit will be completed within 30 days.</p> <p>Ongoing, the Administrator will review 100% of recertification documentation for evidence of care coordination completed per policy.</p> <p>A form entitled "Inter-Agency Coordination of Patient Care" has been created as an additional tool for the care coordination process</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager</p>	

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	<p>services were being provided to the patient. At 4:05 p.m., the clinical supervisor explained entity D was contacted for coordination of care, and entity D began physical therapy services with the patient on 7/10/2020. She also explained entity C stopped servicing the patient in March of 2020.</p> <p>During an interview on 8/7/2020 at 10:50 a.m., the clinical supervisor indicated there was no care coordination documentation in the clinical record with entity E since 3/26/2020.</p> <p>Review of an agency document titled "Patient Referral Information" dated 1/13/16, indicated the patient was receiving services from 7 a.m. - 10 a.m. and 2:30 p.m. - 5:30 p.m. daily.</p> <p>Review of an agency document titled "Plan of Care" for certification period 5/4/2020 - 7/2/2020 dated 4/25/2020 indicated the patient was to receive home health aide services 5-7 days a week, 25-42 hours a week and entity E also provided services.</p> <p>Review of an agency document titled "June 2020 Calendar for [patient #3]" evidenced the patient was not provided home health aide services for 3 hours in the afternoon on 6/2/2020, 6/3/2020, 6/4/2020, 6/6/2020, 6/7/2020, 6/9/2020, 6/13/2020, 6/14/2020, 6/17/2020, 6/20/2020, 6/21/2020, 6/27/2020, 6/28/2020 and 6/29/2020. The clinical record failed to evidence the agency coordinated care with entity E regarding patient needs.</p> <p>During an interview on 8/7/2020 at 10:53 a.m., the alternate administrator indicated the patient was typically scheduled with the agency to receive home health aide services from 8 a.m. -11 a.m. and 2 p.m. to 5 p.m. 7 days a week. The alternate</p>		<p>or Clinical Designee on a quarterly basis to ensure documentation reflects care coordination is completed for all interdisciplinary agencies providing care for a client at least once every certification period.</p> <p>Responsible Party: Administrator</p> <p>Date of Completion: August 31, 2020</p>	

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N 0506 Bldg. 00	<p>administrator explained entity E provided attendant care services daily from 11 a.m. to 2 p.m.. The alternate administrator further explained the agency's schedule for home health aides had to work around entity E's schedule, and if the agency's home health aides were unavailable to work the typical shift, the patient's schedule was adjusted so that not to interfere with entity E's schedule. The alternate administrator indicated he would look for documentation of coordination of care with entity E regarding the scheduling of staff to meet patient needs. At 11:50 a.m., the alternate administrator indicated he did not have any documentation of care coordination with entity E.</p> <p>410 IAC 17-12-3(b)(2)(D)(iii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (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.</p> <p>Based on record review and interview, the agency failed to ensure the patient was informed of the change in the plan of care related to the frequency of skilled nursing visits in 1 of 3 records receiving skilled nursing services in a total sample of 7 clinical records reviewed. (#2)</p> <p>The findings include:</p> <p>Review of an agency policy revised 4/20/2020</p>	N 0506	<p><i>Disclaimer:</i></p> <p><i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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</i></p>	08/20/2020

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	<p>titled "Patient/Client Rights and Responsibilities" stated, "... Each patient/client will be an active, informed participant in their plan of care. To ensure this process, the patient/client will be empowered with certain rights and responsibilities. ... A patient/client may designate someone to act as his/her representative ... to act as a patient's/client's legal representative. This authorized representative may exercise any of the rights provided by the policies and procedures on behalf of the patient/client. ... Home care patients/clients have the right to: ... Participate in, be informed about and consent or refuse care in advance of and during treatment, with respect to: ... The frequency of visits ... Receive all services outlined in the plan of care and be informed, in advance, of any changes [sic] to the plan of care...."</p> <p>Clinical record review on 8/4/2020 for patient #2 evidenced an agency document titled "Agreement For Homecare Services" dated by the patient's responsible party on 11/13/18 which indicated the patient was to receive 77-128 hours a week, 4-7 days a week of skilled nursing services.</p> <p>Record review of an agency document titled "Plan of Care" for certification period 3/16/19 - 5/14/19 evidenced the patient was to receive skilled nursing services for 68-112 hours a week, 4-7 days a week. The clinical record failed to evidence the patient's responsible party was informed of the change in skilled nursing frequency.</p> <p>Record review of an agency document titled "Plan of Care" for certification period 1/10/2020 - 3/9/2020 evidenced the patient was to receive skilled nursing services for 40-66 hours a week, 4-7 days a week. The clinical record failed to evidence the patient's responsible party was</p>			<p><i>reserves the right to contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to ensure the patient was informed of the change in plan of care related to the frequency of skilled nursing visits.</p> <p>1. Patient #2 was discharged on May 6, 2020.</p> <p>2. Administrator educated all internal staff, including Clinical Supervisors, Recruiters and Field Support, on policy "Patient/Client Rights and Responsibilities" regarding the requirement that each patient/client will be an active, informed participant in their plan of care, including the right to be informed about and consent or refuse care in advance of or during treatment with respect to frequency of visits, receive all services outlined in the plan of care and be informed, in advance, of any changes to the plan of care.</p> <p>This education was provided to all clinical supervisors during a clinical team meeting on August</p>

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	<p>informed of the change in skilled nursing frequency to 40-66 hours a week, 4-7 days a week.</p> <p>During an interview on 8/7/2020 at 11:50 a.m., the alternate administrator indicated although there was email correspondence about the change of the patient's insurance between himself and the patient's legal guardian, it did not indicate the patient's legal guardian was informed of the change in frequency.</p>		<p>19, 2020 as evidenced by the meeting agenda and signed education acknowledgement.</p> <p>This education was provided to all recruiters and field support during an office team meeting on August 20, 2020 as evidenced by signed education acknowledgement.</p> <p>3. Ongoing, the Administrator or Designee will be responsible for informing the responsible party of changes in frequency as evidence by documented logging.</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure documentation accurately reflects that the responsible party was informed of changes in frequency.</p> <p>Responsible Party: Administrator</p> <p>Date of Completion: August 20, 2020</p>	

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N 0522 Bldg. 00	<p>410 IAC 17-13-1(a) Patient Care</p> <p>Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on record review and interview, the agency failed to provide the services as written in the individualized plan of care in 4 of 7 clinical records reviewed. (#2, #3, #4, #6)</p> <p>The findings include:</p> <p>1. Review of an agency policy revised 4/10/2020 titled "Home Health Certification and Plan(s) of Care" stated, "... The Home Health Certification and Plan of Care (485) is the physician's order for home care services. ... 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(s)...."</p> <p>2. Clinical record review on 8/4/2020 for patient #2 evidenced an agency document titled "Plan of Care" for certification period 1/10/2020 - 3/9/2020 and signed by the physician, which indicated the patient was to receive skilled nursing services 4-7 days a week. The clinical record failed to evidence the patient was provided skilled nursing services for at least 4 days a week during the weeks of 1/12/2020 and 2/16/2020.</p> <p>Review of untitled agency documents dated 1/16/2020, 1/17/2020, 2/17/2020, 2/18/2020,</p>	N 0522	<p><i>Disclaimer:</i></p> <p><i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to provide the services as written in the individualized plan of care.</p> <p>1. Patient #2 was discharged on May 6, 2020.</p> <p>Patient #3 was discharged on</p>	08/27/2020

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	<p>2/19/2020 and 2/20/2020 indicated services were canceled and stated, "... Caregiver Canceled - No Back-Fill"</p> <p>During an interview on 8/7/2020 at 9:55 a.m., the administrator indicated skilled nursing services were scheduled on 1/16/2020, 1/17/2020, 2/17/2020, 2/18/2020, 2/19/2020 and 2/20/2020 but there was not any available staff so the shifts were canceled. The administrator further indicated skilled nursing services were not provided to the patient per the plan of care.</p> <p>Record review evidenced an agency document titled "Plan of Care" for certification period 3/10/2020 - 5/8/2020 and signed by the physician on 3/5/2020, which indicated the patient was to receive skilled nursing services for 40-66 hours a week, 4-7 days a week.</p> <p>Record review of an agency document titled "General Notes" dated 3/16/2020 stated, "... Advised [patient's legal guardian] that we will put services on hold until further notice" The clinical record failed to evidence a physician's order indicating services were put on hold.</p> <p>Record review of an agency document titled "Treatment/Order Update/Change in Condition" completed and signed by registered nurse on 5/8/2020 stated, "... Discharge client from Maxim Healthcare services effective 5/8/2020...." The clinical record failed to evidence skilled nursing services were provided after 3/12/2020.</p> <p>During an interview on 8/7/2020 at 9:52 a.m., the administrator indicated the patient's family did not want nursing services during the pandemic and skilled nursing services were not provided per the plan of care. The administrator indicated there was</p>			<p>August 31, 2020</p> <p>Patient #6 was discharged on August 12, 2020</p> <p>Patients #2,3, and 6 any additional missed shifts were faxed to the corresponding physicians and retained in medical record upon discharge.</p> <p>Patient #4 Patient #4 – clerical error was corrected on certification 3/15/2020-5/13/2020 and going forward accurately ensuring the individual needs of this client.</p> <p>Administrator educated 100% of Clinical Supervisors on policy "Home Health Certification and Plan of Care" on the requirement the Plan of Care will be individualized to include, but not limited to, services authorized to be provided by direct care staff. Additionally, the Administrator educated all internal staff, including Clinical Supervisors, Recruiters and Field Support, on policy "Patient/Client Scheduling"</p> <p>This education was provided to all</p>	

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	<p>not a physician's order to place the patient's services on hold.</p> <p>3. Clinical record review on 8/4/2020 for patient #3 evidenced an agency document titled "Plan of Care" for certification period 7/3/2020 - 8/31/2020, dated and signed by the physician on 7/1/2020, which indicated the patient was to receive home health aide services for 26-42 hours a week. The clinical record failed to evidence the patient was provided home health aide services for at least 26 hours the week of 7/19/2020.</p> <p>During an interview on 8/3/2020 at 5:08 p.m., the patient indicated she has gone days without services in the past. The patient also indicated staff is not always consistent with their schedule, and sometimes the staff had to leave early or arrived late.</p> <p>During an interview on 8/4/2020 at 1:30 p.m., the administrator indicated the agency has had difficulty staffing the patient at times due to the family dynamics in the home between the patient and the son.</p> <p>During an interview on 8/7/2020 at 10:49 a.m., the alternate administrator explained the patient was typically scheduled with the agency to receive home health aide services from 8 a.m. -11 a.m. and 2 p.m. to 5 p.m. 7 days a week. The alternate administrator further explained the patient's schedule does not typically change and any deviation to the regular schedule is most likely due to a staffing issue. The alternate administrator indicated the home health aide that typically worked the afternoon shift on the weekends had a child care issue and sometimes could not stay until 5 p.m..</p>			<p>clinical supervisors during a clinical team meeting on August 27, 2020 as evidenced by the meeting agenda and signed education acknowledgement.</p> <p>This education was provided to all recruiters and field support during an office team meeting on August 27, 2020 as evidenced by signed education acknowledgement.</p> <p>.</p> <p>2. Operations Manager 100% audit of client's frequency and duration to ensure needs are being met per current schedule. Audit completed 8/27/2020. Any discrepancy /missed shifts will sent to the corresponding physician</p> <p>Ongoing, Missed shift notification sent to physician for notification of deviation from POC</p> <p>3. Ongoing, Office Leadership or Designee will be responsible for reviewing the client's 485 during the recertification process for accuracy in frequency and duration to ensure documentation accurately reflects the services provided per the individual plan of care.</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	<p>4. Clinical record review on 8/5/2020 for patient #4 evidenced an agency document titled "Plan of Care" for certification period 1/15/2020 - 3/14/2020, signed and dated by the physician on 1/8/2020, which indicated the patient was to receive home health aide services 2-3 days a week. The clinical record evidenced the patient received home health aide services 4 days a week during the week of 1/19/2020, 1/26/2020, 2/2/2020, 2/9/2020, 2/16/2020, 2/23/2020, 3/1/2020 and 3/8/2020.</p> <p>During an interview on 8/6/2020 at 3:27 p.m., the administrator indicated the plan of care ordered the patient to receive home health aide services 2-3 days a week, but the patient received services 4 days a week. The administrator indicated there was not a supplemental physician's order for the increase in frequency.</p> <p>5. Clinical record review on 8/5/2020 for patient #6 evidenced an agency document titled "Plan of Care" for certification period 5/12/2020 - 7/10/2020 signed by the physician on 5/14/2020 which indicated the patient was to receive skilled nursing services 3-5 days a week, 30-50 hours a week. The clinical record failed to evidence the patient received skilled nursing services from 6/20/2020 to 7/1/2020 and failed to evidence a physician's order putting the patient's services on hold.</p> <p>During an interview on 8/6/2020 at 10:20 a.m., the administrator indicated the family was on vacation and requested no services from 6/20/2020 to 7/1/2020. The administrator also indicated the clinical record did not contain a physician's order placing the agency's services on hold and services were not provided as ordered in the plan of care.</p>		<p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure documentation accurately reflects that the responsible party was informed of changes in frequency.</p> <p>Responsible Party: Administrator</p> <p>Date of Completion: August 27, 2020</p>	

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N 0524 Bldg. 00	<p>6. During an interview on 8/6/2020 at 3:15 p.m., the administrator indicated the agency does not request a supplemental order from the physician to place patient's services on hold when requested by the patient or patient's family.</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. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on observation, record review and interview, the agency failed to individualize the plan of care to include all medications, supplies and equipment and patient-specific interventions and education in 1 of 2 home visits conducted. (#1)</p>	N 0524	<p><i>Disclaimer:</i></p> <p><i>By submitting this POC the agency does not admit the allegations in the survey report or that it the survey report or that it violated any regulations. The</i></p>	09/04/2020

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	<p>The findings include:</p> <p>Review of an agency policy revised 4/10/2020 titled "Home Health Certification and Plan(s) of Care" stated, "... The Plan of Care shall include, but not limited to: ... Listing of all medications, including the over-the-counter ... Listing of all equipment and supplies"</p> <p>During an observation of care at the home of patient #1 on 8/4/2020 at 10:07 a.m. with employee C, registered nurse (RN), and employee F, home health aide (HHA), present, clotrimazole (medication to treat fungal infection) and triple antibiotic ointment (medication to treat bacterial infection) were observed on the shelves in the patient's room and an air mattress was observed under the patient in the bed. At 10:14 a.m., a tube placed into the patient's abdomen was noted. At 10:29 a.m., soft restraints were observed attached to the side rails on each side of the bed. At 10:38 a.m., 4 wounds and 1 scar were noted to the top of the patient's left hand.</p> <p>Clinical record review on 8/4/2020 for patient #1 evidenced an agency document titled "Assessment" dated 7/10/2020 which indicated the patient had a g-tube (a surgically inserted tube into the stomach through the abdomen to deliver nutrition) and received a tube feeding continuously via a feeding pump.</p> <p>Review of an agency document titled "Plan of Care" for certification period 7/21/2020 - 9/18/2020 failed to evidence the tube feeding supplies such as the feeding pump and the air mattress were included in the patient's supplies in the plan of care. The document also failed to evidence the clotrimazole and triple antibiotic ointment</p>		<p><i>agency is submitting this POC in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to individualize the plan of care to include all medications, supplies, and equipment and patient specific interventions.</p> <p>1. Employee F was provided education on August 13th 2020 by Clinical Supervisor as evidenced by logging in personnel file.</p> <p>Administrator educated 100% of clinical supervisors on the requirement for Home Health Certifications and Recertification for completion to include, but not be limited to, listing all medications including OTC, equipment, and supplies.</p> <p>This education was provided to all clinical supervisors during a clinical team meeting on August</p>	

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	<p>medications in the plan of care.</p> <p>During an interview on 8/4/2020 at 10:28 a.m., the patient's step-father indicated the clotrimazole and triple antibiotic ointment were applied sometimes to the patient's skin.</p> <p>During an interview on 8/4/2020 at 10:33 a.m., employee F, HHA, indicated she has been caring for the patient for 5 years and the restraints have been there for as long as she can remember.</p> <p>Employee F indicated at times the family uses the restraints when the patient bites her hand.</p> <p>Employee F further indicated she does not use the restraints but per the family's direction, the home health aide explained and demonstrated how she wraps a cloth around the patient's left hand and sits next to the patient's bed and holds the patient's left hand.</p> <p>During an interview on 8/4/2020 at 10:43 a.m., employee C, RN, indicated she is aware of the wounds to the left hand and stated, "they come and go." Employee C further indicated the treatment for the wounds was for staff to protect the area on the left hand.</p> <p>During an interview on 8/6/2020 at 3:25 p.m., the clinical supervisor indicated all medications, supplies and equipment should be included on the patient's individualized plan of care. The clinical supervisor further indicated the use of restraints on the patient by the family should be included in the plan of care as well as the individualized interventions of wrapping the left hand with a cloth and holding the patient's left hand to prevent the patient from self-inflicted bite wounds.</p>		<p>27, 2020 as evidenced by the meeting agenda and signed education acknowledgement.</p> <p>2. The clinical supervisor will audit 100% of the patient Plans of care for accuracy of current medications, equipment, and supplies.</p> <p>The Administrator will review 100% recertifications weekly to ensure the patients current medication, including OTC, equipment, and supplies are updated and reflected in the documentation within 30 days.</p> <p>3. Ongoing the clinical supervisors will continue to review Plans of care for accuracy of current medications, equipment, and supplies during the recertification process</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure the aide plan of care accurately reflects services ordered in the medical plan of care</p>	

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N 0527 Bldg. 00	<p>410 IAC 17-13-1(a)(2) Patient Care</p> <p>Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on observation, record review and interview, the agency failed to promptly alert the physician to changes in the patient's condition or needs that suggest the plan of care should be altered in 1 of 2 home visits in a total sample of 7 clinical records reviewed. (#1)</p> <p>The findings include:</p> <p>Review of an agency policy revised 7/30/2020 titled "Ongoing Evaluation" stated, "... The Direct Care Staff shall notify the office clinical leader or clinical designee and/or physician when there is a change in the patient condition which might warrant a change in medication and/or a change to the plan of care. ... The physician will be notified to verify any changes in ... care, treatment, or services that require physician approval...."</p> <p>Review of an agency policy revised 2/16/2020 titled "Restraints" stated, "... The office clinical leader or clinical designee will contact the physician to obtain an order for the use of a</p>	N 0527	<p>Responsible Party: Administrator</p> <p>Date of completion 9/4/2020</p> <p><i>Disclaimer:</i></p> <p><i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to promptly alert the physician to changes in the patient's condition or</p>	09/04/2020

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	<p>restraint...."</p> <p>During an observation of care at the home of patient #1 on 8/4/2020 at 10:29 a.m., with employee C, registered nurse (RN), and employee F, home health aide (HHA), present, soft restraints were observed attached to the side rails on each side of the bed. At 10:38 a.m., 4 wounds and 1 scar were noted to the top of the patient's left hand.</p> <p>Clinical record review on 8/4/2020, for patient #1, evidenced an agency document titled "Plan of Care" for certification period 7/21/2020 - 9/18/2020, signed by the physician on 7/16/2020, which failed to evidence the family's use of restraints on the patient, behaviors exhibited by the patient and wounds to the left hand.</p> <p>Record review on 8/6/2020, evidenced an agency document titled "Assessment" dated 8/4/2020, and completed by employee C, RN, which stated, "... pt [patient] bites the back of her hand as part of her behaviors. skin is discolored from past injuries. ... apprx [approximately] 5 small areas of scabs noted ... HHA applies a towel around pt hand to prevent injury...." The document failed to evidence the physician was notified of the family's use of restraints on the patient and of the wounds to the left hand.</p> <p>During an interview on 8/4/2020 at 10:33 a.m., employee F, HHA, indicated she has been caring for the patient for 5 years and the restraints have been there for as long as she can remember. Employee F indicated at times the family uses the restraints when the patient bites her hand. Employee F further indicated she does not use the restraints but per the family's direction, she described and demonstrated how she wraps a cloth around the patient's left hand and sits next</p>		<p>needs that suggest the plan of care should be altered.</p> <p>1.Employee C (Clinical Supervisor) was educated 1:1 by administrator on 8/26/2020</p> <p>Patient #1 EMR has been updated with the following effective 8/26/2020:</p> <ul style="list-style-type: none"> ·Assessment 8/4/2020- added a late logging of correction noting GT assessment missed and include detailed info. ·Logging, supplemental order for new medication profile added for medication noted during 8/4/2020 visit. ·Updated wound documentation in POC. ·Added family use of restraints and follow up with physician for supplemental order ·Family education provided regarding safe use of restraints ·New assessment and care coordination with other agency completed 8/26/2020. ·DME and safety precautions updated. ·HHA written plan of care updated. <p>Administrator educated 100% of clinical supervisors on the</p>	

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	<p>to the patient's bed and holds the patient's left hand when the patient bites her left hand.</p> <p>During an interview on 8/4/2020 at 10:43 a.m., employee C, RN, indicated she is aware of the wounds to the left hand and stated, "They come and go." The alternate clinical supervisor further indicated the treatment for the wounds was for the staff to protect the area on the left hand.</p> <p>During an interview on 8/6/2020 at 3:27 p.m., the clinical supervisor indicated the physician should be notified of changes in the patient's condition to include wounds, the use of restraints on the patient by the family, patient behaviors and the individualized intervention of wrapping the left hand with a cloth and holding the patient's left hand to prevent the patient from biting the hand. The clinical supervisor further explained even if staff was not applying restraints, the physician would be notified, an order would be obtained and the plan of care would be updated to include the use of restraints.</p>		<p>requirement to promptly alert the patient's physician of any changes that suggest a need to alter the plan of care.</p> <p>Education occurred on 8/27/2020 as evidenced by signed acknowledgment.</p> <p>Change in condition education was provided to Employee F by Clinical Supervisor on August 13th 2020 as evidenced by Employee F personnel file logging.</p> <p>The administrator will educate 100% of unskilled caregivers on requirement to notify the agency clinical supervisor of changes in patient condition.</p> <p>This education was provided to all direct caregivers via mailer on August 18, 2020 as evidenced by documentation of a signed, electronic, or verbal acknowledgement. This education will be completed by September 4, 2020.</p>	

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			<p>Beginning 8/19/2020 the clinical supervisors will review 100% of unskilled shift documentation weekly for compliance of change in condition notification. This audit will be completed within 30 days.</p> <p>2. The Administrator will review 100% of recertification assessments weekly for evidence that any changes to the patients care or status that could alter the current plan of care have been communicated to the patient's physician for 30 days</p> <p>3. The Administrator will continue to run change in condition report weekly to ensure all identified changes are reported per policy.</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure the aide plan of care accurately reflects services ordered in the medical plan of care. _</p> <p>Responsible Party: Administrator</p>	

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

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FORM APPROVED
OMB NO. 0938-039

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N 0541 Bldg. 00	<p>410 IAC 17-14-1(a)(1)(B) Scope of Services</p> <p>Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:</p> <p>(B) Regularly reevaluate the patient's nursing needs.</p> <p>Based on observation, record review and interview, the agency failed to ensure the comprehensive assessment accurately reflected the patient's current health, psychosocial, functional and cognitive status and failed to ensure all medications the patient was currently taking were reviewed in 1 of 2 clinical records reviewed with a home visit. (#1)</p> <p>The findings include:</p> <p>Review of an agency policy revised 4/22/19 titled "Reassessments/Recertifications" stated, "... A follow-up comprehensive assessment or recertification is conducted by a qualified clinician</p>	N 0541	<p>Date of completion 9/04/2020</p> <p><i>Disclaimer:</i></p> <p><i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of</i></p>	09/04/2020

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	<p>to identify the patient's current health status ... The comprehensive assessment must be updated and revised ... as frequently as the patient's condition warrants ... The update of the comprehensive follow-up assessment must, at a minimum, include: ... Completion of a comprehensive assessment to reflect any changes in the patient status ... Drug regimen review of all medications to include: ... Drug interactions ... Potential adverse effects and drug reactions ... The medication profile will be updated as needed ... The medication profile will include both prescription and over the counter...."</p> <p>Review of an agency policy revised 9/12/16 titled "Wound Care" stated, "... Documentation of wound measurement(s) will be noted and include a description of: ... wounds size; length; width and depth. ... Wound bed tissue: type/color, necrotic, slough, eschar, granulating and epithelial ... Evidence of wound healing or deterioration"</p> <p>Review of an agency policy revised 7/8/19 titled "Medication Profile" stated, "... Patients receiving medications will have a current and accurate Medication Profile maintained in the medical record and the home folder. ... The comprehensive medication history will include the following: ... The Medication Profile will include: ... A list of all current patient medications, prescribed, over-the-counter (OTC) or herbal remedies ... The patient's medications are reviewed and compared to the Medication Profile during each skilled shift/visit...."</p> <p>During an observation of care at the home of patient #1 on 8/4/2020 at 10:07 a.m., with employee C, registered nurse (RN), and employee F, home health aide (HHA), present, clotrimazole (medication to treat fungal infection) and triple</p>			<p>Compliance.</p> <p>The agency failed to ensure the comprehensive assessment accurately reflected the patient's current health, psychosocial, functional and cognitive status and failed to ensure all medications the patient was currently taking were reviewed.</p> <p>1.Employee C (Clinical Supervisor) was educated 1:1 by administrator on 8/26/2020</p> <p>Patient #1 EMR has been updated with the following effective 8/26/2020:</p> <ul style="list-style-type: none"> ·Assessment 8/4/2020- added a late logging of correction noting GT assessment missed and include detailed info. ·Logging, supplemental order for new medication profile added for medication noted during 8/4/2020 visit. ·Updated wound documentation in POC. ·Added family use of restraints and follow up with physician for supplemental order ·Family education provided

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	<p>antibiotic ointment (medication to treat bacterial infection) were observed on the shelves in the patient's room.</p> <p>During an observation of care at the home of patient #1 on 8/4/2020 at 10:14 a.m. with employee C, registered nurse (RN), and employee F, home health aide (HHA), present, a tube placed into the patient's abdomen was noted. At 10:29 a.m., soft restraints were observed attached to the side rails on each side of the bed. At 10:38 a.m., 4 wounds and 1 scar were noted to the top of the patient's left hand.</p> <p>Clinical record review on 8/4/2020 for patient #1 evidenced an agency document titled "Plan of Care" for certification period 7/21/2020 - 9/18/2020 which indicated the patient received g-tube (a tube surgically inserted into the stomach through the abdomen to deliver nutrition) feedings.</p> <p>Clinical record review on 8/4/2020 agency documents titled "Plan of Care" for certification period 7/21/2020 - 9/18/2020 and "Patient Medication Profile" dated 8/4/2020 failed to evidence the clotrimazole and triple antibiotic ointment medications were listed as the patient's medications.</p> <p>Record review on 8/6/2020 for patient #1 evidenced an agency document titled "Assessment" dated 8/4/2020 and completed by employee C, RN, which indicated the patient did not have a feeding tube (a tube surgically inserted into the abdomen to deliver nutrition). The document further stated, "... pt [patient] bites the back of her hand as part of her behaviors. skin is discolored from past injuries. ... no open areas. apprx [approximately] 5 small areas of scabs noted...." The document failed to include an</p>		<p>regarding safe use of restraints</p> <ul style="list-style-type: none"> ·New assessment and care coordination with other agency completed 8/26/2020. ·DME and safety precautions updated. ·HHA written plan of care updated. <p>The Administrator educated 100% of clinical supervisors on the requirement for assessments to reflect current health, psychosocial, functional and cognitive status, and review all medications and treatments for accuracy.</p> <p>This education occurred on 8/27/2020 as evidenced by meeting agenda and signed acknowledgment.</p> <p>2. The clinical supervisors will review and update as necessary 100% of the patients medication profiles for accuracy of current medications.</p> <p>The Administrator will review 100% recertification assessments weekly to ensure the patients current health, psychosocial,</p>	

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	<p>assessment of the patient's g-tube to include patency, size and assessment of the g-tube site such as skin color and drainage. The document also failed to include an assessment of the wounds to include size, location and color of surrounding skin. The document failed to include an assessment of the family's use of restraints on the patient.</p> <p>Record review on 8/6/2020 of agency documents titled "Assessment" and "Supervisory Visit V3" dated 8/4/2020 and completed by employee C, RN, failed to evidence a medication review of clotrimazole and triple antibiotic ointment was completed.</p> <p>During an interview at the entrance conference on 8/3/2020 at 9:49 a.m., the clinical supervisor indicated when a new medication is found in the home than what is on the plan of care, the clinician is to contact the physician for a supplemental order and update the medication profile. The clinical supervisor also indicated the medication review is completed when the medication profile is updated in the electronic medical record.</p> <p>During an interview on 8/4/2020 at 10:28 a.m., the patient's step-father indicated the clotrimazole and triple antibiotic ointment were applied sometimes to the patient's skin.</p> <p>During an interview on 8/4/2020 at 10:33 a.m., employee F, home health aide (HHA), indicated she has been caring for the patient for 5 years and the restraints have been there for as long as she can remember. Employee F indicated at times the family uses the restraints when the patient bites her hand. Employee F also indicated the patient usually has wounds to her left hand due to biting</p>		<p>functional and cognitive status, and medication reconciliation, are updated and reflected in the documentation within 30 days.</p> <p>3. The clinical supervisors will continue to complete comprehensive assessment as part of the admission and recertification process.</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure the aide plan of care accurately reflects services ordered in the medical plan of care.</p> <p>Party responsible Administrator</p> <p>Date of Completion: 9/04/2020</p>	

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N 0603 Bldg. 00	<p>herself.</p> <p>During an interview on 8/4/2020 at 10:43 a.m., the alternate clinical supervisor indicated she is aware of the wounds to the left hand and stated, "They come and go."</p> <p>During an interview on 8/6/2020 at 5:05 p.m., the clinical supervisor indicated the scabs are eschar (a collection of dead tissues within the wound) and implied that eschar is a description of a wound. The clinical supervisor indicated the comprehensive assessment should include the use of restraints on the patient by the family, assessment of the wounds to include location, size, color of surrounding skin and drainage and assessment of the g-tube to include patency, size and assessment of the g-tube site such as skin color and drainage.</p> <p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide may not be assigned to perform additional tasks not included in the original competency evaluation until he or she has successfully been evaluated as competent in that task.</p> <p>Based on observation, record review and interview, the agency failed to assign the home health aide to patients with written patient care instructions in 1 of 1 home visits with the home health aide in a total sample of 7 clinical records reviewed. (#1)</p> <p>The findings include:</p> <p>Review of an agency policy revised 7/8/19, titled "Home Health Aide Plan of Care" stated, "... The Home Health Aide Plan of Care (HHA POC) will be</p>	N 0603	<p><i>Disclaimer:</i></p> <p><i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and</i></p>	09/04/2020

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	<p>individualized to the specific patient and will include at least: ... Type of services/procedures to be provided ... Specific procedure(s) to be performed, including amount, frequency and duration ... Safety measures, including specific equipment ... Each patient receiving home health aide services will have an individualized plan developed by the Registered Nurse ... The developed HHA POC is to be utilized to direct care performed by the assigned aide. ... Home Health Aide shall not make any modifications in the care they are instructed to provide except by the written updates to the HHA POC as modified by the Professional.... The HHA POC will be reviewed at least every 60 days as a component of the recertification comprehensive assessment. If there are no changes to the HHA POC, the Professional shall document the review on the supervisory visit form. If there are significant changes to the HHA POC, the Professional shall complete a new HHA POC form which reflects the changes clearly described... "</p> <p>During an observation of care at the home of patient #1 on 8/4/2020 at 10:29 a.m., with employee C, registered nurse (RN), and employee F, home health aide (HHA), present, soft restraints were observed attached to the side rails on each side of the bed.</p> <p>Clinical record review on 8/4/2020 for patient #1, evidenced an agency document titled "Aide - Care Plan" last reviewed and signed by the RN on 5/2/18 which failed to evidence written instructions on how the home health aide was to provide protection to the patient when the patient demonstrated behaviors to include attempts to bite herself.</p> <p>Record review on 8/6/2020, evidenced an agency</p>		<p><i>deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to assign the home health aide to patients with written patient care instructions.</p> <p>1. Patient #1 EMR updated including Written HHA care plan</p> <p>2. 1:1 education with Employee C (Clinical Supervisor) occurred 8/26/2020 provided by Administrator</p> <p>Administrator educated 100% of clinical supervisors on the requirement for a Skilled Nurse to develop and update an aide plan of care for all patients receiving home health aide services to ensure the aide plan of care accurately reflects services ordered on the medical plan of care</p> <p>This education occurred 8/27/2020 as evidenced by signed acknowledgement</p> <p>3. The Clinical Supervisors will</p>	

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	<p>document titled "Assessment" dated 8/4/2020, and completed by employee C, RN, which stated, "... pt [patient] bites the back of her hand as part of her behaviors. skin is discolored from past injuries. apprx [approximately] 5 small areas of scabs noted ... HHA applies a towel around pt hand to prevent injury...." This document failed to evidence changes were made to the home health aide plan of care to include directions for the home health aide to apply a towel to the patient's hand to prevent injury when the patient attempted to bite herself.</p> <p>Record review on 8/6/2020, evidenced an agency document titled "Supervisory Visit V3 dated 8/4/2020 and completed by employee C, RN, which failed to evidence changes were made to the home health aide plan of care to include directions for the home health aide to apply a towel to the patient's hand to prevent injury when the patient attempted to bite herself.</p> <p>During an interview on 8/4/2020 at 10:29 a.m., employee F, HHA, explained and demonstrated how she wraps a cloth around the patient's left hand and sits next to the patient's bed and holds the patient's left hand to prevent the patient from biting herself.</p> <p>During an interview on 8/4/2020 at 10:43 a.m., employee C, RN, indicated the treatment for the wounds on the patient's left hand was for staff to protect the area when the patient attempted to bite herself.</p> <p>During an interview on 8/6/2020 at 5:06 p.m., the clinical supervisor indicated the registered nurse should update the home health aide plan of care to include patient-specific interventions the staff is to provide to prevent the patient from biting her</p>		<p>review 100% of HHA care plans and ensure they have had a competency evaluation on all tasks ordered by 9/4/2020.</p> <p>The administrator will review 100% of recertification documentation weekly for compliance; including care coordination completed and the updated aide care plan accurately reflects the medical plan of care. This audit will be completed within 30 days.</p> <p>4. To ensure this alleged deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure the aide plan of care accurately reflects services ordered in the medical plan of care.</p> <p>Responsible Party: Administrator</p> <p>Date of completion 9/04/2020</p>	

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N 0604 Bldg. 00	<p>hand.</p> <p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist.</p> <p>Based on observation, record review and interview, the home health aide failed to report changes in the patient's condition to a registered nurse or other appropriate skilled professional in 2 of 4 records reviewed with home health aide services in a total sample of 7 clinical records reviewed. (#1, #5)</p> <p>The findings include:</p> <p>1. Review of an agency policy revised 4/10/2020 titled "Care Coordination/Case Conference" stated, "... Care coordination is accomplished through communication with the members of the health care team ... Interdisciplinary coordination of care is ensured through communication and case conferencing. ... Evidence of the care coordination must be documented in the medical record or system of record. ... Direct Care Staff shall communicate changes in patient status amongst the assigned personnel and the office clinical leader or clinical designee. ... Direct Care Staff will communicate changes in a timely manner via telephone, one-on-one meetings, case conferences and/or home visits...."</p> <p>2. During an observation of care at the home of patient #1, on 8/4/2020 at 10:29 a.m., with employee C, registered nurse (RN), and employee F, home health aide (HHA) present, soft restraints were observed attached to the side rails on each side of the bed.</p>	N 0604	<p><i>Disclaimer:</i></p> <p><i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to report changes in the patient's condition to a registered nurse or other appropriate skilled professional.</p> <p>1. Patient #1 EMR including written HHA plan of care updated.</p> <p>This education was provided to</p>	09/04/2020

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	<p>Clinical record review on 8/4/2020, for patient #1, evidenced an agency document titled "Plan of Care" for certification period 7/21/2020 - 9/18/2020 and agency documents titled "Assessment" dated 6/10/2020 and 7/10/2020 which failed to evidence the family's use of restraints on the patient.</p> <p>During an interview on 8/4/2020 at 10:33 a.m., employee F, HHA, indicated she has been caring for the patient for 5 years and the restraints have been there for as long as she can remember. Employee F indicated at times the family uses the restraints when the patient bites her hand.</p> <p>During an interview on 8/4/2020 at 10:43 a.m., employee C, RN, indicated she was not aware of the restraints.</p> <p>During an interview on 8/6/2020 at 3:31 p.m., the clinical supervisor indicated the home health aide should inform the RN case manager of the family's use of restraints on the patient. The clinical supervisor further explained even if staff was not applying restraints, the physician would be notified, an order would be obtained and the plan of care would be updated to include the use of restraints.</p> <p>3. Clinical record review on 8/5/2020, for patient #5, evidenced a document labeled "Aide Weekly Note" dated 9/26/2016 and 9/27/2016 on which employee G, home health aide (HHA), indicated patient #5 complained of pain in legs and catheter. Clinical record review failed to show evidence of communication from employee G to clinical supervisor regarding patient's pain.</p> <p>During an interview on 8/7/2020 at 9:38 a.m., employee A, clinical manager, indicated the HHA is to notify clinical supervisor if patient has pain</p>		<p>employee F by clinical supervisor on August 13, 2020 as evidenced by employee F personnel note logging.</p> <p>2. The administrator will educate 100% of unskilled caregivers on requirement to notify the agency clinical supervisor of changes in patient condition.</p> <p>This education was provided to all direct caregivers via mailer on August 18, 2020 as evidenced by documentation of a signed, electronic, or verbal acknowledgement. This education will be completed by September 4, 2020.</p> <p>Beginning 8/19/2020 the clinical supervisors will review 100% of unskilled shift documentation weekly for compliance of change in condition notification. This audit will be completed within 30 days.</p> <p>3. The Administrator will run the change in condition report weekly to ensure all changes to patient status are identified and reported per policy</p> <p>4. To ensure this alleged</p>	

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N 0614 Bldg. 00	<p>or any change in condition and a coordination note should be made documenting communication.</p> <p>410 IAC 17-15-1(c) Clinical Records Rule 15 Sec. 1(c) Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to service.</p>	N 0614	<p>deficiency does not recur, 10 or 10%, whichever is greater, of the active patient census will be reviewed by the Clinical Manager or Clinical Designee on a quarterly basis to ensure that changes in condition are reported per policy.</p> <p>Responsible Party: Administrator Date of completion 9/04/2020</p> <p><i>Disclaimer:</i></p>	09/04/2020

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	<p>Based on observation, record review and interview, the agency failed to safeguard the clinical record, its contents and the information contained therein from loss or unauthorized use.</p> <p>The findings include:</p> <p>Review of an agency policy dated 1/1/15 titled "Maxim Information Security Policy" stated, "... All Company Personnel are responsible for keeping Company Information, especially Protected Information, protected from loss and from unauthorized access, modification, destruction, or disclosure...."</p> <p>At time of entrance to the agency on 8/3/2020 at 9:45 a.m., an envelope addressed to the office of person B was observed unsecured on top of a mailbox outside of the entrance door to the agency. A sticky note was attached to the envelope which stated, "Outgoing Please pick up Thank you ..."</p> <p>Review of an agency document on 8/3/2020 at 10:45 a.m. inside an envelope addressed to person B evidenced a letter to patient #3 which indicated the patient was being discharged from the agency and stated, "... you would benefit from a higher level of care, which cannot be provided by our offices...." This document also indicated the patient's first and last name, her address and the name of her primary care physician.</p> <p>During an interview on 8/3/2020 at 10:45 a.m., the administrator indicated in the envelope was a copy of the discharge notice from the clinical record for patient #3 which was being mailed to the physician and placed on top of the mailbox outside for the mail carrier to pick-up. The administrator indicated the usual protocol was to</p>		<p><i>By submitting this POC the agency does not admit the allegations in the survey report or that it 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 contract any alleged findings. Conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i></p> <p>The agency failed to safeguard the clinical record, its contents and the information contained therein from loss or unauthorized use.</p> <p>1. Field Support Manager provided 1:1 education to person responsible for outgoing mail on 8/14/2020. Education evidenced by personnel logging.</p> <p>2. Administrator reeducated 100% of internal team members on the Maxim Information Security Policy. Education to office team occurred 8/20/2020. As evidenced by signed acknowledgment.</p>	

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	place outgoing in the tray on top of the receptionist's desk inside to keep the patient's information protected.		<p>3. Going forward all outgoing mail, including protected information will be secured within the office at all times.</p> <p>4. To ensure alleged deficiency does not reoccur the Administrator will ensure all HIPAA practices are followed throughout the branch during quarterly self auditing process.</p> <p>Responsible Party: Administrator</p> <p>Date of completion 9/04/2020</p>	