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

PRINTED: 04/11/2014 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157591	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/04/2014		
NAME OF PROVIDER OR SUPPLIER  MAXIM HEALTHCARE SERVICES INC				4646 W	ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON BLVD STE 100 WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
G000000	investigation.  Complaint #: If Unsubstantiated evidence. Unrecited.  Survey date: A Facility #: 0037  Medicaid #: 200  Surveyor: Mirit PHNS  Quality Review BSN, RN	l: Lack of sufficient lated deficiencies are pril 4, 2014	G00	00000	Pursuant to federal and state law the HHA hereby submits this Plan of Correction and allegation of compliance for the deficiencies noted. This Plan of Correction do not, however, constitute an admission that the deficiency exis or existed or that the deficiency was properly cited.	es	

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
157591		B. WING			04/04/2014		
l					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					/ JEFFERSON BLVD STE 100		
MAXIM HEALTHCARE SERVICES INC					WAYNE, IN 46804		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX			PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
G000166	ORDERS	WITH PHYSICIAN put in writing and signed					
		e date of receipt by the					
		r qualified therapist (as					
	defined in section	in section 484.4 of this chapter) sible for furnishing or supervising the					
	Based on clinical record review, policy		G00	00166	<b>G 166</b> For Patient #3, the primary	04/09/2014	
	review, and inter	view, the agency failed			care physician will be contacted by		
	· ·	an orders obtained were			clinical staff and confirmation of		
		for 1 of 3 clinical records			verbal order for extra hours to		
	reviewed with the potential to affect all				cover colonoscopy the week of		
		•			03-09-14 through 03-15-14 will be		
	the agency's patients. (#3)  Findings include  1. Clinical record #3, start of care 3/13/12, contained a Home Health Certification and Plan of Care dated 3/2-4/30/14 with orders for skilled nurse (SN) every 2 weeks and as needed foley change and Home Health Aide (HHA) 5-7 days a week for 21-35 hours a week times 60 days. An order dated 3/20/14 increased the HHA services to a total of				documented.  The Director of Clinical Services will		
					provide in-service education to both	,	
					internal clinical and non-clinical staf		
					regarding acceptance and carrying		
					out of physician orders during		
					weekly		
					team meeting on 4-9-14. This		
					in-service		
					will include review of company		
					policy		
					requirements as stated in policy titled,		
					"Processing of Physician Orders"		
					MD-CL-010.7. Clinical Supervisors		
	38-63 hours per	week through 3/29/14.			will		
	Visits were provided at 46 hours the week of 3/9-3/15 over six days. The				sign a letter of attestation		
					acknowledging		
		evidence an order for			receipt and understanding of		
		the week of 3/9-3/15/14.			education		
	increased nours t	THE WEEK OF 3/9-3/13/14.			provided.		
	2 0 4/4/14 1 1 20 1 25				Effective immediately, all clients		
		11:20 AM, employee A			requiring a supplemental physician order for increase in hours will be		
	_	ency obtained an order for			tracked in office on specified white		
increased HHA service hours due to the				Tracked in office off specified willte			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I5YU11

Facility ID: 003757

If continuation sheet Page 2 of 6

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		л ріш	a. Building 00		COMPLETED			
		157591	B. WING 04/04/2014			2014		
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	CR CR						
MAXIM HEALTHCARE SERVICES INC				4646 W JEFFERSON BLVD STE 100 FORT WAYNE, IN 46804				
	LALITIOANE SEI	WICES INC		TOKTV	VATNE, IN 40004			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	patient had to p	rep for a colonoscopy and			board to ensure order has been			
	needed help to t	the bathroom.			written,			
					received and forwarded to			
	3 On 4/4/14 at	11:35 AM, employee A			appropriate			
					parties. This process will ensure all			
		gency could not find the			orders are written in a timely			
	order.				manner			
					and complete with physician			
	4. The agency's	s policy titled "Processing			signature			
	of Physician Or	ders," #MD-CL-010.7,			according to policy MD-CL-010.7.			
	_	and effective 4/7/14 states,			Director of Clinical Services and			
		ill be obtained from a			Accounts			
					Manager will provide education to			
		ian (or other qualified			all			
		provider) for care and			internal staff during weekly team			
	services to be provided 3.2. As				meeting			
	applicable, orders will be signed and dated within 30 days from the original				on 4-9-14.			
					To prevent this alleged deficiency			
		5.3.1. For a			from			
	•	rder: 5.3.1.1. Designee			reoccurring, the Director of Clinical Services will monitor physician			
^^		•			orders			
	will enter the date the office received the				as received by internal clinicians			
		d and dated order.			through			
	5.3.1.2. Designee will remove the copy of the computer generated order from the medical record and replace with the Physician signed and date stamped order.				mandatory quarterly medical record	,		
					reviews.	·		
					These medical record reviews			
					require at			
		ee will maintain the			least 10 medical records or 10% of			
	_	ritten order in the Medical			census,			
		itten order in the Medical			whichever is greater, to be reviewed	d		
	Record."				quarterly and will be ongoing.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I5YU11

Facility ID: 003757

If continuation sheet Page 3 of 6

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

PRINTED: 04/11/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	, DIM DDIG	00	COMPLETED	
	157591	A. BUILDING		04/04/2014	
		B. WING	A DODDEG CHEV CHARE THE CODE		
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE		
	IEALTHOADE OFDWOED INC		/ JEFFERSON BLVD STE 100		
MAXIM F	HEALTHCARE SERVICES INC	FORT	WAYNE, IN 46804		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
N000000					
	This was a State home health complaint	N000000	Pursuant to federal and state law,		
	investigation.		the HHA hereby submits this Plan		
	investigation.		of Correction and allegation of		
			compliance for the deficiencies		
	Complaint #: IN00145688-		noted. This Plan of Correction doe	s	
	Unsubstantiated: Lack of sufficient		not, however, constitute an		
	evidence. Unrelated deficiencies are		admission that the deficiency exist	:s	
	cited.		or existed or that the deficiency		
	onea.		was properly cited.		
	G 1. A 31.4.2014				
	Survey date: April 4, 2014				
	Facility #: 003757				
	Medicaid #: 200484160				
	Wedledid #. 200404100				
	Surveyor: Miriam Bennett, RN, BSN,				
	PHNS				
	Quality Review: Joyce Elder, MSN,				
	BSN, RN				
	April 7, 2014				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		157591	B. WING			04/04/	2014
			B. WIIVE	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					JEFFERSON BLVD STE 100		
MAXIM HEALTHCARE SERVICES INC					WAYNE, IN 46804		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDENCE N. AV OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG				TAG			DATE
N000547	410 IAC 17-14-1(a	ı)(1)(H)					
	Scope of Services	,,,,					
	Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health						
		red nurse shall do the					
	following: (H) Accept and ca	arry out physician					
	chiropractor, podia						
	optometrist orders						
	Based on clinical record review, policy		N000547	0547	N547 For Patient #3, the primary		04/09/2014
		view, the agency failed			care		
	to ensure physician orders obtained were placed in record for 1 of 3 clinical records reviewed with the potential to affect all the agency's patients. (#3)				physician will be contacted by		
					clinical		
					staff and confirmation of verbal		
					order		
					for extra hours to cover colonoscopy	У	
					the week of 03-09-14 through		
	Findings include	;			03-15-14		
					will be documented.		
	1. Clinical record #3, start of care 3/13/12, contained a Home Health Certification and Plan of Care dated				The Director of Clinical Services will		
					provide in-service education to both internal clinical and non-clinical staff		
					regarding acceptance and carrying	'	
	3/2-4/30/14 with orders for skilled nurse				out of physician orders during		
	(SN) every 2 weeks and as needed foley change and Home Health Aide (HHA)				weekly		
					team meeting on 4-9-14. This		
					in-service		
		for 21-35 hours a week			will include review of company		
	times 60 days. A	an order dated 3/20/14			policy		
	increased the HHA services to a total of 38-63 hours per week through 3/29/14.				requirements as stated in policy		
					titled,		
	Visits were provi	ided at 46 hours the			"Processing of Physician Orders"		
		over six days. The			MD-CL-010.7. Clinical Supervisors		
	record failed to evidence an order for increased hours the week of 3/9-3/15/14.  2. On 4/4/14 at 11:20 AM, employee A				will		
					sign a letter of attestation		
					acknowledging		
					receipt and understanding of		
					education		
	indicated the agency obtained an order for				provided.		

State Form Event ID: | I5YU11 | Facility ID: 003757 | If continuation sheet | Page 5 of 6

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	00	COMPLETED		
		157591	B. WIN			04/04/2	2014
		l .		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				4646 W	JEFFERSON BLVD STE 100		
MAXIM HEALTHCARE SERVICES INC					VAYNE, IN 46804		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	increased HHA s	service hours due to the			Effective immediately, all clients		
	patient had to pro	ep for a colonoscopy and			requiring		
	needed help to the				a supplemental physician order for		
	noodod noip to th	-			increase in hours will be tracked in		
	2 On 4/4/14 at	11:25 AM amplayaa A			office		
	3. On 4/4/14 at 11:35 AM, employee A indicated the agency could not find the				on specified white board to ensure		
		ency could not find the			order		
	order.				has been written, received and		
					forwarded		
	4. The agency's policy titled "Processing of Physician Orders," #MD-CL-010.7, revised 3/6/14 and effective 4/7/14 states,				to appropriate parties. This process will		
					ensure all orders are written		
					in a timely manner and complete		
	"3.1. Orders wil	l be obtained from a			with		
		an (or other qualified			physician signature according to		
		•			policy		
	non-physician provider) for care and services to be provided 3.2. As applicable, orders will be signed and dated within 30 days from the original date of receipt 5.3.1. For a supplemental order: 5.3.1.1. Designee will enter the date the office received the physician signed and dated order. 5.3.1.2. Designee will remove the copy of the computer generated order from the medical record and replace with the				MD-CL-010.7.		
					Director of Clinical Services and		
					Accounts		
					Manager will provide education to		
					all		
					internal staff during weekly team		
					meeting		
					on 4-9-14.		
					To prevent this alleged deficiency		
					from		
					reoccurring, the Director of Clinical		
					Services will monitor physician orders as		
		and date stamped order.			received by		
	5.3.1.3. Designee will maintain the original handwritten order in the Medical				internal clinicians through		
					mandatory		
	Record."				quarterly medical record reviews.		
					These		
					medical record reviews require at		
					least		
					10 medical records or 10% of census	5,	
					whichever is greater, to be reviewed	i	
					quarterly and will be ongoing.		

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