

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157573	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/23/2014
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NAME OF PROVIDER OR SUPPLIER  AMERICAN HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 940 WEST US HIGHWAY 30 SCHERERVILLE, IN 46375
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G000000	<p>This visit was for a home health partial extended recertification survey.</p> <p>Dates of survey: 10-20 to 10-23-2014</p> <p>Facility #: 004699</p> <p>Medicaid Vendor #: 200804120A</p> <p>Surveyors: Deborah Franco, RN, PHNS Nina Koch, RN, PHNS</p> <p>Unduplicated census past 12 months: 58</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 29, 2014</p>	G000000		
G000159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p>			

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 that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Based on observation, clinical record review, policy review, and interview, the facility failed to ensure the plan of care included all the durable medical equipment the patient had in the home for 1 of 5 home visit patients (patient 10) with the potential to affect all 12 of the agency's active patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During home visit to patient 10 on 10-21-14 at 2:00 PM, a nebulizer and a Trilogy 100 bi-pap machine were observed in the home and the patient indicated these were used in daily care. The plan of care for the certification period 10-9 to 12-7-2014 failed to evidence these items.</li> <li>2. Agency policy "Plan of Care", last reviewed/revised 8-20-14, stated, "The Plan of Care shall be completed in full to include: ... a. Medical supplies and equipment required."</li> <li>3. On 10-23-14 at 3:30 PM, the Administrator / Director of Nursing indicated the Plan of Care for patient 10 did not contain all the durable medical equipment.</li> </ol>	G000159	G159 The Administrator / Director of Nursing and Alternate Director of Nursing have in-serviced the Nursing staff, Physical and Occupational therapists, Home Health Aide, Medical Social Worker and Office staff to ensure the Plan of Care include all Durable Medical Equipment (DME) the patient has at home. A DME profile list will be incorporated with the chart and will be written in Line 14 of Form CMS-485. 10% of all clinical records and plan of care will be audited every 60 days to include medical supplies and equipment the patient requires. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/14/2014	

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G000337	<p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include 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> <p>Based on observation, clinical record review, policy review, and interview, the facility failed to ensure the medication profile contained all the medications the patient was taking for 1 of 5 home visits with the potential to affect all 12 active agency patients (patient 5).</p> <p>Findings include:</p> <p>1. On 10-22-14 at 10:30 AM, a home visit was made to patient 5. Employee D, a Registered Nurse, performed a medication check of all the patient's prescription drugs and over the counter medications the patient was taking. The medication profile in the clinical record</p>	G000337	G337 The Administrator / Director of Nursing and Alternate Director of Nursing have inserviced the Nursing staff and Physical therapists to adhere with the Policy of Medication Reconciliation. Clinicians were instructed that on every visit, to focus on patient medications such as their prescriptions, over the counter drugs, herbal supplements, creams, ointments and to reconcile them with their physician. To query patients for any concerns, problems and medications that is newly prescribed or drugs that were forgotten to report the past visit. 10% of all clinical records with Medication Profile will be audited every 60 days as Drug Regimen Review. The Alternate Director of Nursing will be responsible for	11/14/2014

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	<p>failed to include Glucose tablets 4 grams and Desitin as over the counter drugs. Patient 5 was also taking Calcitriol 0.25 mcg, but Caltrate 600 was listed on the medication profile. The medication profile also failed to list a prescription cream compounded from bupivacaine, dexamethasone and other active ingredients. Lisinopril was listed as on hold on 10-4, but the patient had been taking it twice a day. Patient 5 indicated he/she was using all the above noted medications.</p> <p>2. Agency policy " Policy on Medication Reconciliation", last reviewed/revised 8-20-14, stated, "A complete list of a patient's current medication, allergies, and medication sensitivities will be obtained and documented upon admission to Home Health Agency. ... Clinicians query patients about medication changes, use, new orders, and/or compliance issues on admission and each home visit thereafter."</p> <p>3. On 10-23-14 at 3:30 PM, the Administrator / Director of Nursing indicated the medication profile completed 10-4-14 at start of care was not complete and accurate for patient 5, and there was no further documentation demonstrating compliance.</p>		<p>monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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N000000	<p>This visit was for a state Home Health relicensure survey.</p> <p>Dates of survey: 10-20 to 10-23-2014</p> <p>Facility #: 004699</p> <p>Medicaid Vendor #: 200804120A</p> <p>Surveyors: Deborah Franco, RN, PHNS Nina Koch, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 29, 2014</p>	N000000		
N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a</p>			

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	<p>skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <p>(i) Mental status.</p> <p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on observation, clinical record review, policy review, and interview, the facility failed to ensure the plan of care included all the durable medical equipment the patient had in the home for 1 of 5 home visit patients (patient 10) with the potential to affect all 12 of the agency's active patients.</p> <p>Findings include:</p> <p>1. During home visit to patient 10 on 10-21-14 at 2:00 PM, a nebulizer and a Trilogy 100 bi-pap machine were observed in the home and the patient indicated these were used in daily care. The plan of care for the certification</p>	N000524	N524 The Administrator / Director of Nursing and Alternate Director of Nursing have in-serviced the Home Health Staff including RN, PT, OT, MSW, HHA and Office staff to ensure the Plan of Care include all Durable Medical Equipment (DME) the patient has at home. A DME profile list will be incorporated with the chart and will be written in Line 14 of Form CMS-485 for patient care. 10% of all clinical records and plan of care will be audited every 60 days to include medical supplies and equipment the patient requires. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/14/2014

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	<p>period 10-9 to 12-7-2014 failed to evidence these items.</p> <p>2. Agency policy "Plan of Care", last reviewed/revised 8-20-14, stated, "The Plan of Care shall be completed in full to include: ... a. Medical supplies and equipment required."</p> <p>3. On 10-23-14 at 3:30 PM, the Administrator / Director of Nursing indicated the Plan of Care for patient 10 did not contain all the durable medical equipment.</p>			