STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157649	A. BUILDING 00 B. WING	07/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOME HEALTHCARE SERVICES, INC	1035 WALL ST STE 104-C1 JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0000 Bldg. 00	This was a Federal home health validation survey. Survey Dates: July 28 to July 31, 2015 Facility #: 012675 Medicaid Vendor #: 201118080A Unduplicated 12 month census: 209 Records Reviewed: 13 Home visits: 5 QA; LD, R.N.	G 0000		
G 0158 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on observation, interview, clinical record and agency policy review, the home health agency failed to ensure that care followed the plan of care for 2 of 4 (#2 and 4) observed home visits.	G 0158	The Director of Nursing (DON) conducted an in-service with concerned RN regarding physician order and following Care Plan on 08/19/15. Director of Nursing educated the concerned RN to refer the care plan and follow care plan, also to inform family/caregiver on	08/19/2015

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

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	Findings: 1. Clinical record #2,start of care 6/2/2015, contains a plan of care established by the patients physician for the certification period 6/4/2015-8/2/2014 with orders to assess patient's weight log every visit for diagnosis of congestive heart failure (CHF). During a home visit observation on July 29th at 12:30 PM employee C, a registered nurse failed to assess the patient's daily weight log. When asked during the visit interview if the patient maintained a daily weight log to monitor for fluid weight gain related to CHF the caregiver stated that they "did not keep a daily weight log." 2. Clinical record #4, start of care date 7/22/2015 indicates diagnoses of aftercare for traumatic hip fracture and rheumatoid arthritis. The record includes a plan of care established by the patient's physician which includes orders to report to physician if patient experiences pain level not acceptable to the patient or pain level greater than 5 using a 0-10 pain scale. During a home visit observation on 7/30/2015 at 9:30 AM, employee D, an occupational therapist failed to assess the patient's pain using the pain scale		interventions that require their attention such as keeping vital log/weight log when staff not present per individualized care plan. The Director of Nursing circulated the copy of policy on “Weighing for CHF Patients” among concerned RN and all field staff. The DON emphasized to use same weighing scale and to check patient wearing one layer of clothing during weighing. The DON also emphasized during the in-service that use the log sheet which is inside the folder, call MD if the parameters are out of range as per policy. QA/QI Nurse was made responsible to check the compliance that the weight is recorded, during routine chart audit. The DON was made also responsible to make random supervisory visits checking the patient’s folder at home verify weight logs are properly done and noted as per required policy and the Plan of Care. 	

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	while the patient was performing range of motion and strengthening exercises. 3. An undated agency policy titled Care Planning Process #2-018.1 states " The care planning decisions will be reflected in the specific associated actions planned and implemented to meet individualized problems and goals."			
N 0000 Bldg. 00	This was a state re-licensure survey. Survey Dates: July 28 to July 31, 2015 Facility #: 012675 Medicaid Vendor #: 20118080A Unduplicated 12 month census: 209 Records Reviewed: 13 Home visits: 5 QA; LD, R.N.	N 0000		

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N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on observation, interview, clinical record and agency policy review, the home health agency failed to ensure that care followed the plan of care for 2 of 4 (#2 and 4) observed home visits. Findings: 1. Clinical record #2,start of care 6/2/2015, contains a plan of care established by the patients physician for the certification period 6/4/2015-8/2/2014 with orders to assess patient's weight log every visit for diagnosis of congestive heart failure (CHF). During a home visit observation on July 29th at 12:30 PM employee C, a registered nurse failed to assess the patient's daily weight log. When asked during the visit interview if the patient maintained a daily weight log to monitor for fluid weight gain related to CHF the caregiver stated that they "did not keep a daily weight log."	N 0522	The Director of Nursing (DON) conducted an in-service with concerned OT regarding physician order and following care plan on 08/19/15. Director of nursing educated the concerned OT that she has to take all the vital signs, and have care plans available to follow, inform family/caregiver on interventions that require their attention such as keeping vital log/weight log when staff is not present per individualized care plan. The Director of Nursing circulated the copy of policy on “pain assessment and management” among concerned OT and all field staff. Also, DON reviewed the policy on“pain assessment and management” with OT and field staff emphasized that the pain assessment is the fifth vital sign which needs to be reported to MD if it’s greater than 5 using the 0 -10 pain scale, as per policy. QA/QI Nurse was made responsible to check the compliance that the pain assessment is done for each visit, during routine chart audit.The DON was made responsible to	08/19/2015

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	2. Clinical record #4, start of care date 7/22/2015 indicates diagnoses of aftercare for traumatic hip fracture and rheumatoid arthritis. The record includes a plan of care established by the patient's physician which includes orders to report to physician if patient experiences pain level not acceptable to the patient or pain level greater than 5 using a 0-10 pain scale. During a home visit observation on 7/30/2015 at 9:30 AM, employee D, an occupational therapist failed to assess the patient's pain using the pain scale while the patient was performing range of motion and strengthening exercises. 3. An undated agency policy titled Care Planning Process #2-018.1 states " The care planning decisions will be reflected in the specific associated actions planned and implemented to meet individualized problems and goals."		make random supervisory visits to observe whether the field staff is asking patient about his/her comfort or whether pain assessment is done and recorded. 	