

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS	STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227
---	---

(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
G000000	<p>This visit was for a Federal Home Health Agency complaint investigation.</p> <p>Facility #: 013272</p> <p>Medicaid vendor:</p> <p>Dates of survey: 12-11-and 12-12-14</p> <p>Complaints # IN00152118 and #IN00157736 - Substantiated: Federal deficiencies related to the allegation are cited.</p> <p># IN00154427 - Unsubstantiated: Lack of sufficient evidence.</p> <p>Surveyor: Deborah Franco, RN, PHNS</p> <p>Census: 16 Skilled Nursing 108 HHA only 124 Total active cases</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>December 18, 2014</p>	G000000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS	STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227
---	---

(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
G000109	<p>484.10(c)(2) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to participate in the planning of the care.</p> <p>The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.</p> <p>Based on clinical record review, policy review, review of agency administrative documents, and interview, the agency failed to ensure the patient and/or legal representative were allowed to participate in the planning of their care to include plans for discharge in 2 of 2 discharge charts reviewed (#1 and #2) with the potential to affect the agency's 124 active patients.</p> <p>Findings include:</p> <p>1. Clinical record (CR) #1, start of care (SOC) 1-15-14, included orders for skilled nursing (SN) 2-3 times each week</p>	G000109	G109 The administrator will inservice all skilled staff on proper charting to document the patient is made aware in advance of their right to participate in planning the care or treatment and in planning changes in the care or treatment. The inservice will include review of the following policies: Plan of Care, Client Discharge Process, Coordination of Client Services, and Home Care Bill of Rights. . For the next 30 days, 100% of admissions, resumptions of care, recertifications, discharges, or patients with any changes will be audited to ensure documentation present to show patient was aware of their right and able to participate in the plan of care/treatment . Quarterly, 10% of	01/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS	STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227
---	---

(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
	<p>and personal services attendant (PSA) 7 times each week. The last SN visit note was dated 6-25-14. The CR failed to evidence 5 days notice to patient prior to discharge from services on 6-26-14.</p> <p>2. Clinical record # 2, SOC 4-24-14, included a plan of care with orders for SN services bi-weekly to monitor nutritional intake, take vital signs, and assist with medication set up. The last SN visit was on 9-17-14. The CR failed to evidence 5 days notice to patient prior to discharge from services on 9-19-14.</p> <p>3. Agency policy "Client Discharge Process", 3-500, undated, states, one of the "purposes of the policy is to assure 5 days minimum notice to patient of discharge." Exceptions noted to the 5 day notice requirement are " if the health, safety, and/or welfare of the agency's employees would be at immediate and significant risk if the agency continued to provide services to the patient; patient's refusal of the home health agency's services; patient's services are no longer reimbursable and the agency informs the patient of community resources to assist the patient following discharge; patient no longer meets applicable regulatory criteria and the agency informs the patient of community resources to assist patient following discharge."</p>		<p>census or 10 patients (whichever is greater) will be audited to ensure documentation exists showing the patient is aware of their right to participate in the plan of care or treatment . The Administrator will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS	STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227
---	---

(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
	<p>4. Agency policy "Home Care Bill of Rights", 3-380, undated, states, "Comfort Keepers shall advise the patient of any change in the plan of care, including reasonable discharge notice ... Comfort Keepers has a policy to give notice of discharge of services to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped ... Comfort Keepers must continue, in good faith, to attempt to provide services during the five (5) day period described ... "</p> <p>5. Agency documents included a letter from Staff D, the previous Administrator, dated 9-19-14 to the legal representative of patient #2 stating the agency would no longer furnish services.</p> <p>6. Staff B, the Director of Nursing (DoN), on 12-12-14 at 1:15 PM, confirmed the above findings and indicated the previous Administrator, Staff D, had initiated the discharges of patients #1 and #2 and had failed to discharge them as per agency policy. The previous Administrator had refused resumption of care of patient #1 upon discharge from hospitalization and had sent a letter to the legal representative for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS	STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227
---	---

(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
G000144	<p>patient #2 on 9-19-14, 2 days after the last SN visit in the CR, notifying the legal representative the agency would no longer furnish services. No further documentation demonstrating compliance or a legitimate reason to discharge patients #1 and #2 without 5 days notice was offered prior to exit.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Based on clinical record review, review of policy, and interview, the agency failed to ensure the clinical record or case conference minutes established effective interchange, reporting, and coordination of the patient's care with another agency for 1 of 2 closed clinical records reviewed (#2) with the potential to affect all agency patients receiving services from an outside agency.</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care of 4-24-14, included a plan of care for certification period of 8-22 to 10-20-14 with orders for skilled nursing (SN) services. The record evidenced the</p>	G000144	G144 The Administrator will inservice all skilled staff on proper charting to document the patient's care was coordinated with all services involved in the care. The inservice will include review of the following policies: Plan of Care, Client Discharge Process, Coordination of Client Services, and Home Care Bill of Rights. . For the next 30 days, 100% of admissions, resumptions of care, recertifications, discharges, or patients with any changes will be audited to ensure documentation present to show coordination of care was done and documented . Quarterly, 10% of census or 10 patients (whichever is greater) will be audited to ensure documentation exists showing the	01/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/12/2014
NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS			STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227		
(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	
G000170	<p>patient also received services of a geriatric case manager from another agency. Discharge was on 9-19-14. The clinical record failed to evidence coordination of services between the agency and an outside agency providing geriatric case management services.</p> <p>2. Agency policy "Coordination of Client Services", 3-360, undated, states, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care ... coordination with other agencies and institutions ... case conferences will documented in the patient record."</p> <p>3. Staff A, the Administrator, on 12-12-14 at 1:15 PM, indicated patient #2 was receiving services from a geriatric case manager but that the clinical record failed to evidence documentation of coordination of care between the SN from this agency and the geriatric case manager from an outside agency.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record review and</p>	G000170	<p>patient is aware of their right to participate in the plan of care or treatment . The Administrator will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur</p> <p>G170 The Administrator will inservice all skilled staff on following the plan of care</p>	01/11/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/12/2014
NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS			STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227		
(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	
	<p>interview, the agency failed to ensure the registered nurse followed the plan of care for 1 of 3 clinical records reviewed (#2) with the potential to affect all agency 124 active patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record of patient # 2, start of care 4-24-14, included a plan of care with orders for Skilled Nursing (SN) visits bi-weekly during the 7-20 to 9-19-14 certification period. The plan of care included an order to provide copies of SN visit notes to the patient's legal representative, the patient's family member, who had power of attorney. The clinical record failed to evidence the copies had been provided. SN visits were made during the certification period on 7-23, 8-14, 8-28 and 9-17-14.</li> <li>2. Agency policy "Plan of Care", 3-580, undated, states agency personnel will " ... follow the plan designated ... "</li> <li>3. Staff B, the Director of Nursing, on 12-12-14 at 1:15 PM, verified the findings and indicated patient #2's SN notes were not provided consistently to the patient's legal representative and SN visits were not made bi-weekly during the certification period as per the plan of care.</li> </ol>		<p>including visit frequency, and proper notification of MD if plan of care is not able to be followed. A review of proper charting to document the patient is made aware in advance of their right to participate in planning the care or treatment and in planning changes in the care or treatment. The inservice will include review of the following policies: Plan of Care, Client Discharge Process, Coordination of Client Services, and Home Care Bill of Rights. . For the next 30 days, 100% of skilled visits will be audited to ensure plan of care is being followed . Quarterly, 10% of census or 10 patients (whichever is greater) will be audited to ensure the plan of care is being followed . The Administrator will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS	STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227
---	---

(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
G000173	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions.</p> <p>Based on clinical record review, review of agency policy, and interview, the agency failed to ensure the registered nurse (RN) initiated necessary revision to the plan of care for 1 of 3 clinical records reviewed (#2) with the potential to affect agency's 124 active patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record #2, start of care 4-24-14, included a plan of care for certification period 8-22 to 10-20-14. The record evidenced the patient's geriatric case manager would not be able to provide some services beginning August 2014. The clinical record failed to evidence the registered nurse contacted the patient's physician requesting additional orders for nursing care and/or increased frequency of visits in August 2014.</li> <li>Agency policy "Plan of Care", 3-580, undated, states, "The plan will be consistently reviewed to ensure that client needs are met, and will be updated as</li> </ol>	G000173	G173 The Administrator will inservice all skilled staff on following the plan of care including visit frequency, and proper notification of MD if plan of care is not able to be followed. A review of proper charting to document the patient is made aware in advance of their right to participate in planning the care or treatment and in planning changes in the care or treatment. The inservice will include review of the following policies: Plan of Care, Client Discharge Process, Coordination of Client Services, and Home Care Bill of Rights. . For the next 30 days, 100% of skilled visits will be audited to ensure plan of care is being followed . Quarterly, 10% of census or 10 patients (whichever is greater) will be audited to ensure the plan of care is being followed . The Administrator will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur	01/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS	STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227
---	---

(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
N000000	<p>necessary ... "</p> <p>3. Staff B, the Director of Nursing (DoN), on 12-12-14 at 1:15 PM, confirmed the above findings, and indicated the agency was aware patient #2's geriatric case manager would not be able to provide some services beginning August 2014. The RN should have contacted the attending physician to revise the plan of care to meet the patient's needs but this did not occur.</p> <p>This visit was for a state Home Health Agency complaint investigation.</p> <p>Facility #: 013272</p> <p>Medicaid vendor:</p> <p>Dates of survey: 12-11-and 12-12-14</p> <p>Complaints # IN00152118 and #IN00157736 - Substantiated: State deficiencies related to the allegation are cited.</p> <p># IN00154427 - Unsubstantiated:</p>	N000000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS	STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227
---	---

(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
N000486	<p>Lack of sufficient evidence.</p> <p>Surveyor: Deborah Franco, RN, PHNS</p> <p>Census: 16 Skilled Nursing 108 HHA only 124 Total active cases</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>December 18, 2014</p> <p>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.</p> <p>Based on clinical record review, review of policy, and interview, the agency failed to ensure the clinical record or case conference minutes established effective interchange, reporting, and coordination of the patient's care with another agency for 1 of 2 closed clinical records reviewed (#2) with the potential to affect all agency patients receiving services from an outside agency.</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care of</p>	N000486	N0486 The Administrator will inservice all skilled staff on proper charting to document the patient's care was coordinated with all services involved in the care. The inservice will include review of the following policies: Plan of Care, Client Discharge Process, Coordination of Client Services, and Home Care Bill of Rights. . For the next 30 days, 100% of admissions, resumptions of care, recertifications, discharges, or patients with any changes will be audited to ensure documentation present to show coordination of care was done and documented . Quarterly, 10% of census or 10	01/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/12/2014
NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS			STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227		
(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	
	<p>4-24-14, included a plan of care for certification period of 8-22 to 10-20-14 with orders for skilled nursing (SN) services. The record evidenced the patient also received services of a geriatric case manager from another agency. Discharge was on 9-19-14. The clinical record failed to evidence coordination of services between the agency and an outside agency providing geriatric case management services.</p> <p>2. Agency policy "Coordination of Client Services", 3-360, undated, states, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care ... coordination with other agencies and institutions ... case conferences will documented in the patient record."</p> <p>3. Staff A, the Administrator, on 12-12-14 at 1:15 PM, indicated patient #2 was receiving services from a geriatric case manager but that the clinical record failed to evidence documentation of coordination of care between the SN from this agency and the geriatric case manager from an outside agency.</p>		patients (whichever is greater) will be audited to ensure documentation exists showing the patient is aware of their right to participate in the plan of care or treatment . The Administrator will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS	STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227
---	---

(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
N000488	<p>410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped.</p> <p>(j) The five (5) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.</p> <p>Based on clinical record review, policy review, review of agency administrative documents, and interview, the agency failed to ensure the patient and/or legal representative were allowed to participate in the planning of their care to include plans for discharge in 2 of 2 discharge</p>	N000488	N0488 The Administrator will inservice all skilled staff to document discharge planning following policy entitled "Client Discharge Process" to include at least 5 days notice is given and coordination of care is documented including the physician notification. A discharge summary will be	01/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS	STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227
---	---

(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
	<p>charts reviewed (#1 and #2) with the potential to affect the agency's 124 active patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record (CR) #1, start of care (SOC) 1-15-14, included orders for skilled nursing (SN) 2-3 times each week and personal services attendant (PSA) 7 times each week. The last SN visit note was dated 6-25-14. The CR failed to evidence 5 days notice to patient prior to discharge from services on 6-26-14.</li> <li>2. Clinical record # 2, SOC 4-24-14, included a plan of care with orders for SN services bi-weekly to monitor nutritional intake, take vital signs, and assist with medication set up. The last SN visit was on 9-17-14. The CR failed to evidence 5 days notice to patient prior to discharge from services on 9-19-14.</li> <li>3. Agency policy "Client Discharge Process", 3-500, undated, states, one of the "purposes of the policy is to assure 5 days minimum notice to patient of discharge." Exceptions noted to the 5 day notice requirement are " if the health, safety, and/or welfare of the agency's employees would be at immediate and significant risk if the agency continued to provide services to the patient; patient's</li> </ol>		<p>completed and sent to the MD as part of discharges. The inservice will include review of the following policies: Plan of Care, Client Discharge Process, Coordination of Client Services, and Home Care Bill of Rights. . For the next 30 days, 100% of discharges will be audited to ensure documentation present to show proper notice and coordination was provided to patients prior to discharge. . Quarterly, 10% of census or 10 patients (whichever is greater) will be audited to ensure documentation exists showing the patient is aware of their right to participate in the plan of care or treatment . The Administrator will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS	STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227
---	---

(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
	<p>refusal of the home health agency's services; patient's services are no longer reimbursable and the agency informs the patient of community resources to assist the patient following discharge; patient no longer meets applicable regulatory criteria and the agency informs the patient of community resources to assist patient following discharge."</p> <p>4. Agency policy "Home Care Bill of Rights", 3-380, undated, states, "Comfort Keepers shall advise the patient of any change in the plan of care, including reasonable discharge notice ... Comfort Keepers has a policy to give notice of discharge of services to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped ... Comfort Keepers must continue, in good faith, to attempt to provide services during the five (5) day period described ... "</p> <p>5. Agency documents included a letter from Staff D, the previous Administrator, dated 9-19-14 to the legal representative of patient #2 stating the agency would no longer furnish services.</p> <p>6. Staff B, the Director of Nursing (DoN), on 12-12-14 at 1:15 PM,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS	STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227
---	---

(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
N000537	<p>confirmed the above findings and indicated the previous Administrator, Staff D, had initiated the discharges of patients #1 and #2 and had failed to discharge them as per agency policy. The previous Administrator had refused resumption of care of patient #1 upon discharge from hospitalization and had sent a letter to the legal representative for patient #2 on 9-19-14, 2 days after the last SN visit in the CR, notifying the legal representative the agency would no longer furnish services. No further documentation demonstrating compliance or a legitimate reason to discharge patients #1 and #2 without 5 days notice was offered prior to exit.</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse followed the plan of care for 1 of 3 clinical records reviewed (#2) with the potential to affect all agency 124 active patients.</p> <p>Findings include:</p>	N000537	N0537 The Administrator will inservice all skilled staff on following the plan of care including visit frequency, and proper notification of MD if plan of care is not able to be followed. A review of proper charting to document the patient is made aware in advance of their right to participate in planning the care or treatment and in planning changes in the care or treatment.	01/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS	STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227
---	---

(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
N000542	<p>1. Clinical record of patient # 2, start of care 4-24-14, included a plan of care with orders for Skilled Nursing (SN) visits bi-weekly during the 7-20 to 9-19-14 certification period. The plan of care included an order to provide copies of SN visit notes to the patient's legal representative, the patient's family member, who had power of attorney. The clinical record failed to evidence the copies had been provided. SN visits were made during the certification period on 7-23, 8-14, 8-28 and 9-17-14.</p> <p>2. Agency policy "Plan of Care", 3-580, undated, states agency personnel will " ... follow the plan designated ... "</p> <p>3. Staff B, the Director of Nursing, on 12-12-14 at 1:15 PM, verified the findings and indicated patient #2's SN notes were not provided consistently to the patient's legal representative and SN visits were not made bi-weekly during the certification period as per the plan of care.</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary</p>		The inservice will include review of the following policies: Plan of Care, Client Discharge Process, Coordination of Client Services, and Home Care Bill of Rights. . For the next 30 days, 100% of skilled visits will be audited to ensure plan of care is being followed . Quarterly, 10% of census or 10 patients (whichever is greater) will be audited to ensure the plan of care is being followed . The Administrator will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS	STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227
---	---

(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
	<p>revisions.</p> <p>Based on clinical record review, review of agency policy, and interview, the agency failed to ensure the registered nurse (RN) initiated necessary revision to the plan of care for 1 of 3 clinical records reviewed (#2) with the potential to affect agency's 124 active patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record #2, start of care 4-24-14, included a plan of care for certification period 8-22 to 10-20-14. The record evidenced the patient's geriatric case manager would not be able to provide some services beginning August 2014. The clinical record failed to evidence the registered nurse contacted the patient's physician requesting additional orders for nursing care and/or increased frequency of visits in August 2014.</li> <li>Agency policy "Plan of Care", 3-580, undated, states, "The plan will be consistently reviewed to ensure that client needs are met, and will be updated as necessary ... "</li> <li>Staff B, the Director of Nursing (DoN), on 12-12-14 at 1:15 PM, confirmed the above findings, and</li> </ol>	N000542	<p>N0542 The Administrator will inservice all skilled staff on following the plan of care including visit frequency, and proper notification of MD if plan of care is not able to be followed. A review of proper charting to document the patient is made aware in advance of their right to participate in planning the care or treatment and in planning changes in the care or treatment. The inservice will include review of the following policies: Plan of Care, Client Discharge Process, Coordination of Client Services, and Home Care Bill of Rights. . For the next 30 days, 100% of skilled visits will be audited to ensure plan of care is being followed . Quarterly, 10% of census or 10 patients (whichever is greater) will be audited to ensure the plan of care is being followed . The Administrator will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur</p>	01/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K117	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/12/2014
NAME OF PROVIDER OR SUPPLIER  COMFORT KEEPERS			STREET ADDRESS, CITY, STATE, ZIP CODE 5214 S EAST STREET, SUITE D1 INDIANAPOLIS, IN 46227		
(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	
	indicated the agency was aware patient #2's geriatric case manager would not be able to provide some services beginning August 2014. The RN should have contacted the attending physician to revise the plan of care to meet the patient's needs but this did not occur.				