

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012349	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/19/2013
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NAME OF PROVIDER OR SUPPLIER COMFORT HOME HEALTH LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1815 S PLATE STREET KOKOMO, IN 46902
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(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) COMPLETE DATE
N 000	<p>Initial Comments</p> <p>This was a home health state complaint investigation.</p> <p>Complaint # IN00139956, Unsubstantiated: Lack of sufficient evidence.</p> <p>Facility #: 012349</p> <p>Medicaid #: 2010004280</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Comfort Home Health is in compliance with the Indiana rules for home health agencies 410 IAC Article 17 Rule 12 section 3 and Rule 13 section 1(a) as related to this complaint.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 25, 2013</p>	N 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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