STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K116	A. BUILDING B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORCARE HOME HEALTH	737 EAST 86TH ST, INDIANAPOLIS, IN, 46240

(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
E0000	Initial Comments An emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42CFR 484.102. Survey Dates: 04-22-204 and 04-23-2024. Active Census: 78 At this Emergency Preparedness survey, Comforcare Home Health was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. QR completed by Area 3-MG, 4-26-2024.	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure survey of a Home	G0000		

	Health Provider. Survey Dates: 04-22-2024 and 04-23-2024 12-Month Unduplicated Skilled Admissions: 0 Census: 78 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. QR completed by Area 3-MG on 4-26-2024.			
G0520	5 calendar days after start of care 484.55(b)(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based on record review and interview, the agency failed to ensure that the Alternate Clinical Manager Registered Nurse (RN), Admin 3, completed the start-of-care comprehensive assessment within 5 days after the start-of-care date in 1 of 2 patients admitted in the last 30 days. (Patient: #8)	G0520	Policy titled "Comprehensive Assessment" was reviewed by the Administrator (Admin 1) with the Clinical Manager/Alternate Administrator (Admin 2) and the Alternate Clinical Manager (Admin 3) on 4/24/2024. Patient #8 Comprehensive Assessment items Pertinent History and/or Previous Outcomes, Patient History and Diagnosis, Primary Caregiver, Functional Limitations, Integumentary Status, Braden Scale, PHQ-2,	2024-05-01

	Findings Include: 1. A review of an agency policy with a review date of 02-01-2024, titled "Comprehensive Assessment" indicated but was not limited to, " ... Comprehensive Assessment, consistent with the client's immediate needs will be completed for all clients in a timely manner, but no later than five (5) calendar days after the Start of Care ... " 2. A review of the clinical record for Patient #8 contained an initial comprehensive assessment dated 04-6-2024, timed from 12:54 PM to 2:35 PM, electronically signed by Admin 3. The initial assessment indicated the primary reason for home health was for a Home Health Aide (HHA) to assist with Activities of Daily Living (ADLs)/Instrumental Activities of Daily /Living (IADLS). The sections "Pertinent History and/or Previous Outcomes" and "Patient History and Diagnoses" were left blank. The "Primary Caregiver" section indicated the caregiver was available and willing to assist with care but failed to list the caregiver's information and what the		Mental/Psychosocial/Cognitive Status, Durable Medical Equipment, Medical Supplies, Rehab Potential, Frequencies, Interventions, Goals, Care Planning and Coordination as well as Discharge Planning were all completed on 4/24/2024 by the Alternate Clinical Manager (Admin 3). 100% of patient Comprehensive Assessments were reviewed by the Clinical Manager/Alternate Administrator (Admin 2) from 4/24/2024 - 5/1/2024 to ensure completion of the Comprehensive Assessment within the policy indicated 5 day time frame. The Clinical Manager/Alternate Administrator will review 100% of all charts for the next 90 days and 10% thereafter to ensure that the comprehensive assessment is being completed within the 5 day timeframe moving forward.	

	caregiver was doing to assist with care needs. The section titled, “Functional Limitations” musculoskeletal was left blank. The “Integumentary Status” section indicated that the turgor was good but failed to assess Patient #8's Arteriovenous (AV) Dialysis fistula (an abnormal connection between an artery and vein). The area titled “Braden Scale” (a scale used for predicting pressure sore risk) was not scored and failed to indicate a total score for Patient #8’s pressure sore risk. The two-question PHQ-2 questionnaire (an assessment that indicates a risk of depression) indicated Patient #8 answered “Not at all” which gave total scores of 0 to both questions. Admin 3 marked “Yes” that Patient #8 indicated a risk for depression but failed to document those risks in the section titled “Mental/Psychosocial/Cognitive Status.” The sections “Durable Medical Equipment (DME)/Medical Supplies, Rehab Potential, Frequencies, Interventions, Goals, Care Planning and Coordination, and Discharging Planning” were blank.			

	A review of a "Face to Face" document signed by Patient #8's physician on 04-12-2024, indicated the patient's medical condition to support home health services as "Homebound, Fall Risk, Chronic Kidney Disease, and Degenerative Disk disease. A review of a verbal physician's order for the start of care dated 04-16-2024 at 8:00 AM, signed by the Clinical Manager, Admin 2, indicated services for Skilled Nursing for supervision of the Home Health Aide services and Home Health Aide services for ADL/IADL for safety. A review of a "Progress Note" from Entity 12, a physician group, dated 10-26-2023 at 3:52 PM, electronically signed by Person 14, the Nurse Practitioner for Person 13, the patient's physician. The progress note indicated, "74-year-old ... who has Vitamin B12 deficiency; Folic acid deficiency; arteriovenous dialysis fistula; End Stage Renal Disease (ESRD) (kidney failure) on hemodialysis (treatment used to filter wastes, salts, and fluid from the blood); Type 2 Diabetes Mellitus (a condition			

	of the body's inability to regulate sugar); Hypertension; Coronary Artery Disease (a condition of narrowing of the major vessels); Chronic Diastolic Congestive Heart Failure (a condition in which the heart's main pumping chamber (left ventricle) becomes stiff and unable to pump effectively); Degeneration of Lumber Intervertebral Disc (a condition where one or more discs in the spine deteriorate due to age, results in neck and back pain); Anemia; Memory loss; History of Deep Vein Thrombosis (DVT) (a condition which the blood clots form in veins located deep inside the body); and Arthritis (joint pain, swelling, and stiffness) ... Patient requires home care services ... patient does not have the arm strength for a manual wheelchair, uses a rollator walker which is supportive, but they do not have endurance for any walking other than short distance and requires a motorized wheelchair ... " During an interview on April 23, 2024, at 1:12 PM, Admin 3 stated they were responsible for submitting the comprehensive assessment within 5 days of the			

	start-of-care date. Admin 3 confirmed Patient #8's start-of-care date was April 16, 2024. Additionally, Admin 3 verified the initial comprehensive assessment for Patient #8 was still pending and they were still working on it by checking the computer system. 3. During an interview on 04-23-2024 at 1:22 PM, the Administrator and Clinical Manager, Admin 2, confirmed Patient #8's initial start-of-care comprehensive assessment was incomplete. The Administrator further confirmed the comprehensive assessment should be completed within 5 days of the start-of-care date.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made;	G0574	Policy titled "Comprehensive Assessment" was reviewed by the Administrator (Admin 1) with the Clinical Manager/Alternate Administrator (Admin 2) and the Alternate Clinical Manager (Admin 3) on 4/24/2024. Patient #8 had the Plan of Care including the start of care date, certification period, orders for specific clinical services and	2024-05-01

	(v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the agency failed to ensure the individualized plan of care included all elements: pertinent diagnosis and their onset date, all supplies and equipment, specific frequency and duration of visits, nutritional requirements, requirements, all accurate medications, allergies, treatments, all necessary interventions to address the underlying risk factors, all safety measures, infection control precautions, a description of the patient's risk for emergency department visits and hospital readmissions, services being provided by outside agencies/facilities, measurable		treatments (frequency and duration), all pertinent diagnosis principal and secondary including date of onset, medical history, allergies, mental status, treatment goals, prognosis, rehabilitation potential, functional limitations and precautions, activities permitted or restrictions, specific dietary or nutritional requirements, medications: dose/frequency/route medical supplies and equipment required, any safety measures to protect against injury, caregiver needs, discharge plans was completed on 4/24/2024 by the Alternate Clinical Manager (Admin 3). Patient #3 had the Plan of Care updated to include the patient's allergies on 4/24/2024 by the Alternate Clinical Manager (Admin 3). 100% of patient Plans of Care were reviewed by the Clinical Manager/Alternate Administrator (Admin 2) from 4/24/2024 - 5/1/2024 to ensure inclusion of the start of care date, certification period, orders	

	identified by the home health agency and patient, rehab potential, discharge planning, and orders may be received/accepted by outside physicians for 2 of 6 active records reviewed. (Patients: #3, and 8) Findings Include: 1. A review of an agency policy revision dated 01-01-2021, titled "Plan of Care" indicated but was not limited to, " ... The plan of care is based on a Comprehensive Assessment and information provided by the client/family and health team ... An individualized Plan of Care signed by a Physician shall be required for each client ...The Plan of Care shall be completed in full, and include: a. Start of Care date b. Certification period ... d. Orders for specific clinical services and treatments (frequency/duration), e. All pertinent diagnosis (es), principal and secondary, including dates of onset f. Medical history ... h. Allergies i. Mental status j. Treatment goals k. Prognosis l. Rehabilitation potential m. Functional limitations and precautions n. Activities permitted or restrictions o.		for specific clinical services and treatments (frequency and duration), all pertinent diagnosis principal and secondary including date of onset, medical history, allergies, mental status, treatment goals, prognosis, rehabilitation potential, functional limitations and precautions, activities permitted or restrictions, specific dietary or nutritional requirements, medications: dose/frequency/route medical supplies and equipment required, any safety measures to protect against injury, caregiver needs, discharge plans. The Clinical Manager/Alternate Administrator will review 100% of all charts for the next 90 days and 10% thereafter to ensure the Plan of Care is completed fully and within 5 days of start of care.	

	Specific dietary or nutritional requirements p. Medications: dose/frequency/route q. Medical supplies and equipment required r. Any safety measures to protect against injury s. Caregiver needs; instructions to client/caregiver, as applicable t. Instructions for timely discharge or referral u. Discharge plans ... " 2. A review of the clinical record for Patient #8 revealed an initial comprehensive assessment dated 04-6-2024, electronically signed by the Registered Nurse (RN)/Alternate Clinical Manager, Admin 3. However, the clinical record failed to contain a plan of care. A review of a "Face to Face" document signed by Patient #8's physician on 04-12-2024, indicated the patient's medical condition to support home health services as "Homebound, Fall Risk, Chronic Kidney Disease, and Degenerative Disk disease. A review of a verbal physician's order for the start of care dated 04-16-2024 at 8:00 AM, signed			

	2, indicated services for Skilled Nursing for supervision of the Home Health Aide services and Home Health Aide services for ADL/IADL for safety. A review of a "Progress Note" from Entity 12, a physician group, dated 10-26-2023 at 3:52 PM, electronically signed by Person 14, the Nurse Practitioner for Person 13, the patient's physician. The progress note indicated, "74-year-old ... who has Vitamin B12 deficiency; Folic acid deficiency; arteriovenous dialysis fistula; End Stage Renal Disease (ESRD) (kidney failure) on hemodialysis (treatment used to filter wastes, salts, and fluid from the blood); Type 2 Diabetes Mellitus (a condition of the body's inability to regulate sugar); Hypertension; Coronary Artery Disease (a condition of narrowing of the major vessels); Chronic Diastolic Congestive Heart Failure (a condition in which the heart's main pumping chamber (left ventricle) becomes stiff and unable to pump effectively); Degeneration of Lumber Intervertebral Disc (a condition where one or more discs in the spine deteriorate due to age,			

	results in neck and back pain); Anemia; Memory loss; History of Deep Vein Thrombosis (DVT) (a condition which the blood clots form in veins located deep inside the body); and Arthritis (joint pain, swelling, and stiffness) ... Patient requires home care services ... patient does not have the arm strength for a manual wheelchair, uses a rollator walker which is supportive, but they do not have endurance for any walking other than short distance and requires a motorized wheelchair ... " During an interview on 04-23-2024 at 1:12 PM, Admin 3 indicated that the plan of care for Patient #8 was in pending status and that they were still working on it. 3. During an interview on 04-23-2024 at 1:22 PM, the Clinical Manager, Admin 2, confirmed Patient #8's plan of care had not been completed. 4. A review of Patient #3's clinical record evidenced a Plan of Care (POC) with a start of care date of 06-15-2023 and a recertification period of			

	electronically signed by the Alternate Clinical Manager (Admin 3), indicated but was not limited to the diagnoses, Parkinson's (a condition of the brain causing issues with movement, pain, and mental health) Fibromyalgia (a chronic disorder causing pain, fatigue, and stiffness), Neurocognitive disorder with Lewy Bodies (protein deposits in the brain on the cells causing issues with memory and thinking), orthostatic hypotension (a drop in blood pressure when a person stands or sits-up suddenly), and Gastroesophageal reflux disease (when stomach acid rises into the esophagus). The POC evidenced a section titled "Allergies" was blank. The POC failed to include the patient's allergies. During an interview with Admin 3 on 04-23-2024 at 02:55 PM, they confirmed Patient #3's allergies were not listed on the POC and indicated the allergies were supposed to be listed on the POC. 410 IAC 17-13-1(a)(1)(D)(i, ii, iii, iv, v, vi, vii, viii, ix, x, xi, xii, xiii)			

N0000	Initial Comments This visit was for a State Re-licensure survey of a Home Health Agency. Survey Dates: 04-22-2024 and 04-23-2024 Census: 78 Unduplicated Skilled Admissions: 0 QR completed by Area 3 on 4-26-2024.	N0000		
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant	N0458	The Administrator (Admin 1) on 4/24/2024 reviewed and had signed the job description with Clinical Manager/Alternate Administrator (Admin 2). The signed job description was placed in the employee record of the Clinical Manager/Alternate Administrator (Admin 2) on 4/24/2024. Policy No. B135 titled "Personnel Files" was reviewed	2024-04-24

	to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the Administrator (Admin 1) failed to ensure a job description was signed and included in the employee record for 1 of 1 Clinical Manager/Alternate Administrator. (Admin 2) Findings Include: 1. A policy titled "Personnel Files" Policy No. B135 with a review date of 07-01-2023 indicated but was not limited to, " ... 2. Personnel files shall be stored securely and may include ... b. Employment Information ... vi. Signed job description ..." 2. During a review of Admin 2's employee file, it failed to evidence a signed job description. During an interview with Admin 1 on 04-23-2024 at 3:45 PM, they indicated Admin 2 had not signed a job description and confirmed Admin 2 should have		by the Administrator (Admin 1) with the Clinical Manager/Alternate Administrator (Admin 2) on 4/24/2024. 100% of employee files were reviewed by the Administrator (Admin 1) from 4/24/2024 - 5/1/2024 to ensure the presence of a signed job description. The Administrator will review 100% of personnel files for the next 90 days and 10% per quarter thereafter to ensure compliance.	

	had a signed job description in their employee file.			
N0460	Home health agency administration/management 410 IAC 17-12-1(g) Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment.	N0460	The Administrator (Admin 1) on 4/24/2024 reviewed and completed the orientation information and checklist for the Clinical Manager/Alternate Administrator (Admin 2) positions. The signed checklist was placed in the employee record of the Clinical Manager/Alternate Administrator (Admin2) on 4/24/2024. Policy No. B135 titled "Personnel Files" was reviewed by the Administrator (Admin 1) with the Clinical Manager/Alternate Administrator (Admin 2) on 4/24/2024. 100% of employee files were reviewed by the Administrator (Admin 1) from 4/24/2024 - 5/1/2024 to ensure the presence of a signed orientation checklist. The Administrator will review	2024-04-24

	Based on record review and interview, the Administrator (Admin 1) failed to ensure there was documentation of orientation to the job included in the employee record for 1 of 1 Clinical Manager/Alternate Administrator. (Admin 2) Findings Include: 1. A policy titled "Personnel Files" Policy No. B135 with a review date of 07-01-2023 indicated but was not limited to, " ... 2. Personnel files shall be stored securely and may include ... b. Employment Information ... ix. Orientation checklist ..." 2. A review of Admin 2's employee file failed to evidence their orientation information and checklist for the Clinical Manager and Alternate Administrator positions. During an interview with Admin 1 on 04-23-2024 at 3:45 PM, they indicated they had not included an orientation checklist in Admin 2's employee file.		100% of personnel files for the next 90 days and 10% per quarter thereafter to ensure compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hayley Murray	Administrator	5/6/2024 12:51:52 PM