

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K144	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  08/23/2024	
NAME OF PROVIDER OR SUPPLIER  COMFORT HOME HEALTH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  1815 S PLATE STREET, KOKOMO, IN, 46902		
(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	<p>Initial Comments</p> <p>An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102 for a Home Health Provider and Supplier.</p> <p>Survey Dates: August 20, 21, 22, and 23, 2024</p> <p>Census: 30</p> <p>At this Emergency Preparedness survey, Comfort Home Health was found to be in compliance with Conditions of Participation 42 CFR 484.102 Emergency Preparedness requirements for Medicare Participating Providers and Suppliers.</p>	E0000		
G0000	<p>INITIAL COMMENTS</p> <p>This visit was for a Federal Recertification and State Re-Licensure survey of a Home</p>	G0000		

	<p>Health Provider.</p> <p>Survey dates: August 20, 21, 22, and 23, 2024.</p> <p>12 Month Unduplicated Skilled Admissions: 5.</p> <p>Partially Extended Survey Announced on 08/21/2024 at 3:05 PM.</p> <p>This deficiency report reflects State findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.</p> <p>QR 9/4/2024 A2</p>			
<p>G0574</p>	<p>Plan of care must include the following</p> <p>484.60(a)(2)(i-xvi)</p> <p>The individualized plan of care must include the following:</p> <ul style="list-style-type: none"> <li>(i) All pertinent diagnoses;</li> <li>(ii) The patient's mental, psychosocial, and cognitive status;</li> <li>(iii) The types of services, supplies, and equipment required;</li> <li>(iv) The frequency and duration of visits to be made;</li> <li>(v) Prognosis;</li> <li>(vi) Rehabilitation potential;</li> <li>(vii) Functional limitations;</li> </ul>	<p>G0574</p>	<p>On 8/26/24 Patient #1 POC was updated via Physician Order to clarify patient goals and make them patient specific and measurable. WNL status defined for this patient to be: "Bowel status will be WNL for patient during this certification period as evidenced by no constipation or diarrhea"; "Urinary elimination will be WNL for patient during this certification period as evidenced by clear yellow urine returned from in and out catheterization". The RN/Case Manager will review each CHH patient's POC at their next</p>	<p>2024-09-21</p>

<p>(viii) Activities permitted;</p> <p>(ix) Nutritional requirements;</p> <p>(x) All medications and treatments;</p> <p>(xi) Safety measures to protect against injury;</p> <p>(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.</p> <p>(xiii) Patient and caregiver education and training to facilitate timely discharge;</p> <p>(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;</p> <p>(xv) Information related to any advanced directives; and</p> <p>(xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.</p> <p>Based on record review, observation, and interview, the agency failed to ensure the plan of care (POC) included all medical equipment, correct quantity of medications, current medications, all safety measures, and patient-specific measurable goals for 4 of 5 active records reviewed (Patient 1,2,3,5).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of an agency policy titled "Practitioners Plan of Treatment" indicated the plan of care must include medications, safety measures, medical equipment, and measurable goals.</li> <li>2. Review of an agency policy</li> </ol>	<p>visit and then every 30 days thereafter to ensure that goals are patient specific and measurable. At each new patient admission patient specific interventions and goals will be addressed based on the individual patient's needs. Each patient's plan of care including goals and interventions will be reviewed with the pt/cg by the Skilled Nurse to ensure that interventions and goals are addressed appropriately as the patient's needs could change. Goals will be patient specific and measurable. Each patient's goals will be tracked by the Skilled Nurse and Clinical Manager to ensure that progress towards goals is achieved. Skilled Nurses re-educated on appropriate patient specific and measurable goals. This re-education includes in-service on Patient Care Policy 2.6.</p> <p>On 8/26/24 Patient #2 POC was updated via Physician Order to clarify patient goals and make them patient specific and measurable. WNL status defined for this patient to be: "Bowel status will be WNL for patient during this certification period</p>	
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Plan" indicated the plan of care should be revised to reflect the changing care needs of the patient.

3. Review of an agency policy titled "Vital Sign Parameters" indicated the physician can establish specific parameters for individual patients and will be written as an order.

4. Review of the clinical record of Patient #1 included plans of care for certification periods 06/11/2024 – 08/09/2024 and 08/10/2024 -10/08/2024 that indicated the following goals: Bowel status will be within normal limits (WNL) for patient and Urinary elimination will be WNL for patient. POC documentation failed to evidence the goals were measurable.

During an interview on 09/21/2024 at 2:50 PM the clinical supervisor indicated the goals with WNL depended on the patient and were not measurable.

5. Review of the clinical record of Patient #2 included plans of care for certification periods 06/20/2024 – 08/18/2024 and 08/19/2024 – 10/17/2024 that

indicated the following goals: Bowel status will be WNL for patient and Urinary elimination will be WNL for patient. POC

as evidenced by no constipation or diarrhea";"Urinary elimination will be WNL for patient during this certification period as evidenced by no difficulties with urination and or no changes in urine color or odor". The RN/Case Manager will review each CHH patient's POC at their next visit and then every 30 days thereafter to ensure that goals are patient specific and measurable. At each new patient admission patientspecific interventions and goals will be addressed based on the individual patient's needs. Each patient's plan of care including goals and interventions will be reviewed with the pt/cg by the Skilled Nurse to ensure that interventions and goals are addressed appropriately as the patient's needs could change. Goals will be patient specific and measurable. Each patient's goals will be tracked by the Skilled Nurse and Clinical Manager to ensure that progress towards goals is achieved. Skilled Nurses re-educated on appropriate patientspecific and measurable goals. This re-education includes inservice on Patient Care Policy 2.6.

<p>G0592</p>	<p>Revised plan of care</p> <p>484.60(c)(2)</p> <p>A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care.</p> <p>Based on record review and interview, the home health agency failed to ensure the revised plan of care (POC) was up-to-date and supported by the comprehensive assessment for 1 of 3 active records reviewed of patients receiving skilled nurse only services (Patient #5).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of an agency policy titled "Development of Care Plan" indicated revisions of the POC are done to reflect the changing care needs of patients.</li> <li>2. Review of the clinical record of Patient #5, start of care date 02/24/2020, included pediatric visit notes completed on 05/28/2024 and 07/27/2024 by licensed practical nurse (LPN) 1</li> </ol>	<p>G0592</p>	<p>Patient #5 Medication Profile reviewed along with POC. Plan of care and Medication Profile updated to accurately reflect the status of patient's wounds being healed. RN/Case Manager is responsible for ensuring appropriate documentation of changes in patient's treatment. As of 8/26/24 patient #5 chart is updated to appropriately reflect her current status. This is to be reviewed by the RN/Case Manager at each nursing visit. All nursing staff re-educated on ensuring each patient's medication profile is correct and up to date.</p>	<p>2024-08-30</p>
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and no wounds were documented.

Review of the plans of care for certification periods 06/02/2024 - 07/31/2024 and 08/01/2024 – 09/29/2024, included treatment orders for the following wound dressings: medihoney wound and burn dressing (assists in the removal of dead tissue and aids in wound healing) to external top of spine twice a day and a wet to dry wound dressing (wet gauze applied to wound, allowed to dry, and dead tissue removed with removal of dressing) to the external base of the spine daily, start date 01/31/2024.

During an interview on 08/22/2024 at 1:29 PM, when asked what wound care is currently being done for Patient #5, LPN 1 indicated Patient #5 has no wounds. When asked when the wound to the top of the spine healed, LPN 1 indicated documentation indicated healed around 02/20/2024. When asked when the wound to the base of the spine healed, LPN 1 indicated documentation indicated healed around 03/08/2024 when Patient #5 was seen by

	<p>Entity 2.</p> <p>Review of physician orders for Patient #5 entered by the clinical supervisor on 08/21/2024 indicated the wound dressing order to the top of the spine discontinuation date, 02/17/2024, and the wound dressing to the base of the spine discontinuation date, 03/29/2024.</p> <p>During an interview on 08/22/2024 at 2:05 PM when asked why the orders to discontinue wound care for Patient #5 were entered on 08/21/2024, the clinical supervisor indicated when records of Patient #5 were requested, he/she entered the orders to discontinue wound care for the wounds that were healed in March 2024.</p>			
<p>G0682</p>	<p>Infection Prevention</p> <p>484.70(a)</p> <p>Standard: Infection Prevention.</p>	<p>G0682</p>	<p>RN #2 &amp; HHA #1 re-educated on the correct way to don and doff gloves along with performing appropriate hand hygiene when caring for a patient via verbal instruction from Clinical Manager. All CHH staff to be re-educated on</p>	<p>2024-09-21</p>

The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.

Based on observation, record review, and interview, the agency failed to ensure infection control practices were upheld for hand hygiene for 2 of 3 active records reviewed with home visits (Patient #2,3).

Findings Include:

1. Review of an agency policy titled "Standard Precautions For All Health Care Workers" indicated hands must be washed or antibacterial solution must be used before and after contact with patient and hand hygiene is required when gloves are removed.

2. During a home visit with Patient #2 on 08/21/2024 at 1:00 PM, registered nurse (RN) 2 was observed applying gloves with no hand hygiene, RN 2 prepared medications and nutritional supplement and administered them through Patient #2 GJ (gastrojejunostomy tube inserted through the abdomen into the stomach and the small intestine to provide an alternative way for feeding) tube. RN 2 removed her gloves

Infection Control, Handwashing and Proper Glove Procedures by 9/21/24 viaonsite skills check and inservice. TheClinical Manager will administer the skills check an inservice by 9/21/24 andthen annually thereafter. The ClinicalManager will perform random in home skill checks every 6 months to ensure thatCHH staff are using appropriate Infection Control Practices.

and failed to perform hand hygiene. RN 2 applied CPT (chest physical therapy vest that uses vibrations to help move mucus out of the lungs) vest to Patient #2. RN 2 applied gloves, without performing hand hygiene, performed oral suctioning, and administered an albuterol nebulizer (turns liquid into an aerosol that can be breathed in through the mouth and nose to loosen mucus in the lungs) treatment. RN 2 removed gloves and failed to perform hand hygiene after removing her gloves.

During an interview on 08/21/2024 at 2:37 PM, when asked what should be done before putting on gloves and after removing gloves, RN 2 indicated she should have washed her hands.

3. During a home visit with Patient #3 on 08/21/2024 at 9:00 AM, home health aide (HHA) 1 was observed wearing gloves and attempting to change the light bulb in Patient's bathroom. HHA 1 removed her gloves and failed to perform hand hygiene after removing her gloves. HHA 1 applied gloves, failed to

	<p>perform hand hygiene and assisted Patient with showering and shampoo. HHA 1 removed her gloves, failed to perform hand hygiene, and donned new gloves. HHA 1 assisted Patient #3 with putting on pants, transferred Patient from shower stool to toilet stool, and applied deodorant and shirt. HHA 1 removed her gloves failed to perform hand hygiene and placed dirty laundry in the washing machine.</p> <p>During an interview on 08/21/2024 during the home visit, when asked what should be done before putting on gloves and after removing gloves, HHA 1 indicated she should have done hand hygiene.</p> <p>410 IAC 17-12-1(m)</p>			
<p>N0000</p>	<p>Initial Comments</p> <p>This visit was for a State Re-Licensure survey of a Home Health Provider.</p>	<p>N0000</p>		

	<p>Survey dates: August 20, 21, 22, and 23, 2024.</p> <p>12 Month Unduplicated Skilled Admissions: 5.</p>			
<p>N0440</p>	<p>Home health agency administration/management</p> <p>410 IAC 17-12-1(a)</p> <p>Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be:</p> <p>(1) clearly set forth in writing; and</p> <p>(2) readily identifiable.</p> <p>Based on record review and interview, the home health agency failed to clearly set forth in writing, administrative control, and lines of authority for the delegation of responsibility down to the patient care level for 1 of 1 agency.</p> <p>Findings include:</p> <p>Review of an agency document dated 04/2024 and titled "Organizational Chart" evidenced the organizational structure of the home health agency. Governing Body branched to the Administrator; Administrator branched to the</p>	<p>N0440</p>	<p>Comfort Home Health OrganizationalChart updated to include lines of authority from the clinical manager, skillednursing, home health aides and scheduler to the patient on 8/26/24. Approved by Board of Directors 9/10/24 The organizational chart will bereviewed annually to ensure that all lines of authority remain intact. Itis the responsibility of the agency Administrator to review this on an annualbasis.</p>	<p>2024-09-13</p>

	<p>Clinical Manager; Clinical Manager branched to the Skilled Nurses and Home Health Aides. The document failed to evidence lines of authority beyond the nurses and home health aides (HHA) who provided care to the patients.</p> <p>During an interview on 08/20/24 at 11:19 AM, the Administrator indicated patients were not included under the nurses and home health aides in the organizational chart.</p>			
<p>N9999</p>	<p>Final Observations</p> <p>Based on record review and interview, the home health agency failed to provide at least three hours of approved dementia training to 1 of 1 home health aide (HHA) employed at least one year and providing care to patient with</p>	<p>N9999</p>	<p>HHA #2 completed initial Dementia Training in 2022 (8 hours). Dementia Training for 2024 still being conducted, as of 8/26/24 an additional 1.6 hours of Dementia Training has been added to the 2024 Education Requirements in the form of an RCTC Course: Approaching Care for Dementia. All CHH home health aide staff will be required to complete this RCTC course by the end of 2024. This will give each CHH home health aide staff member 4.1 hours of Dementia Training</p>	<p>2024-08-26</p>

diagnosis of dementia (HHA 2).

Findings include:

1. Review of the clinical record of Patient #8 included an Aide Care Plan that indicated a diagnosis included, but not limited to, dementia.

Review of a document titled "Schedule Detail View" indicated HHA 2 made all scheduled visits to Patient #8 from 05/13/2024 – 07/09/2024.

2. Review of personnel records evidenced hire date of 02/24/2016 for HHA 2, with completion of 2.5 hours of approved dementia training in 2023 and 2024.

3. During an interview on 08/23/2024 at 11:30 AM, when asked what Dementia training was completed by HHA's, the clinical supervisor indicated the following training was completed: Dementia: Care Basics for 1 hour and Dementia: Challenging Behaviors for 1.5 hours. When asked what additional dementia training was provided, the clinical supervisor indicated no other dementia training was provided.

for 2024. The Clinical Manager will monitor all homehealth aide staff for completion. The three RCTC courses on Dementia will be completed annually by all existing CHH staff who have already performed the initial Dementia Training of 8 hours to give them continued Dementia Training of 4.1 hours annually.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Katie Voorhis

TITLE

Director of Nursing

(X6) DATE

9/16/2024 9:18:31 AM