STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K116	A. BUILDING 00 B. WING	02/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 visit was for a Federal Recertification and State Re-licensure survey in conjunction with a Federal Focused Infection Control in relation to the COVID-19 pandemic. Survey Dates: 2-22, 2-23, 2-24, and 2-25-2021 Facility #: 013284 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. Quality Review completed on 3/8/2021 A4	G 0000		
G 0462 Bldg. 00	484.50(d)(5) Before discharge for cause HHA must: The HHA determines, under a policy set by the HHA for the purpose of addressing discharge for cause that meets the requirements of paragraphs (d)(5)(i) through (d)(5)(iii) of this section, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the HHA to operate effectively is seriously impaired. The HHA must do the following before it discharges a patient for cause: Based on record review and interview, the agency failed to document in the patient's clinical record the behaviors and circumstances that warranted patient discharge for cause as well as their efforts to resolve the problem for 1 of 2 discharged patients reviewed . (Patient #5)	G 0462	Agency Administrator inserviced all nursing staff on 3/8/2021 regarding the incident reporting policy including proper documentation of the incident, investigation of the incident and the resolution of the incident. The	03/08/2021

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

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	Findings include: A review of the Comforcare Home Health Discharge policy, C440, last revision 1/1/2019, indicated, " Clients will receive a 15 (fifteen) day notice of discharge unless the health, safety, or welfare of our staff are in immediate or significant risk if we were to continue to provide services to the patient." During the clinical record review for patient #5, reviewed 02/23/2021, failed to document the circumstance that warranted patient discharge for cause without a 15-day notice on 9/21/20. During an interview with the administrator and alternate administrator, they agreed that an incidence report should have been documented regarding patient #5 cause for discharge. The administrator stated patient #5 sent a text to a drug dealer to deliver drugs to the home while a staff member of their other entity was there. The administrator acknowledge Comforcare staff member was not in the home at the time of the incident. The agency failed to show documentation of the investigation and interviews with patient #5 caregivers. 17-12-3(b)(2)(D)(iii)		agency administrator reviewed the procedure for reporting incidents immediately when notified. 100% of all discharged charts will be reviewed for the next 90 days and 10% of discharged charts audited thereafter to ensure that all incidents are being documented properly. The Clinical Manager is responsible for monitoring this corrective action.	
G 0564 Bldg. 00	484.58(b)(1) Discharge or Transfer Summary Content Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health			

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	care practitioner to ensure the safe and effective transition of care. Based on record review and interview, the agency failed to evidence all necessary medical information pertaining the patient's current course of illness and treatment, post discharge goals of care, and treatments to the receiving facility or health care practitioner to ensure safe and effective transition of care for 2 or 2 discharged patients reviewed. (Patients #5 and #6) Findings include: 1. A review of the Comforcare Home Health policy, C440, last revision 1/1/2019, indicated, " ...To ensure continuity of care, treatment and services need....A discharge plan shall be developed that is documented in writing and includes all written / verbal instruction regarding the clients ongoing care needs and available resources provided to the client and family." 2. The clinical record for patient #5 reviewed 02/23/2021 failed to document that the discharge summary was sent to receiving facility or health care practitioner. The discharge summary dated 9/21/2021 failed to evidence patient #5's post discharge goals of care and treatments. 3. The discharge summary dated 11/24/2021 failed to evidence patient #6's post discharge goals of care and treatments. The agency failed to evidence that patient #6's discharge summary was sent to physician. 4. During an interview with the administrator and alternate administrator, they agreed patient's #5 and #6 progress to goals and treatments and documented that it was sent to transferring facility	G 0564	The Agency Administrator inserviced all nursing staff on 3/8/2021 on the Patient Discharge Policy. The discharge summary is to include the patient's current condition, patient's progress towards goals, patient and family post-discharge instructions, admission and discharge dates, physician responsible for care, reason for admission, type of services provided and the frequency, and the medication profile at time of discharge. The discharge summary should be sent to the physician and to any agency/facility that will be providing care to the patient after discharge. 100% of all discharges will be audited for the next 90 days and 10% of all discharges will be audited quarterly thereafter. The Director of Clinical Services is responsible for monitoring this corrective action.	03/08/2021

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	on the discharge summary.			