| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE | | (X3) DATE SURVEY | |
|--|--|--|-------------|--|-------------------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | COMPLETED |
| | | 157631 | B. WING | | 06/13/2014 |
| NAME OF B | NDOLUDED OD GLIDDLIEI | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | PROVIDER OR SUPPLIEI | K | 1815 S | PLATE STREET | |
| | RT HOME HEALTH | ILLC | KOKON | лО, IN 46902 | <u>.</u> |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | , | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | |
| TAG | 484.12(c) | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| G000121 | COMPLIANCE WPROFESSIONAL The HHA and its a accepted professi principles that appropriate that appropriate in the home health standard infection of 3 (2 and 3) here of 3 (3 and 3) here of 3 (2 and 3) here of 3 (2 and 3) here of 3 (3 and 3) here of 3 (3 and 3) here of 3 (3 and 3) here of 3 (2 and 3) here of 3 (3 and 3) here of 3 and | estaff must comply with items and standards and ply to professionals in an HHA. Items aration and review of agency failed to ensure aide (HHA) followed on control practices for 2 tome health aide visits ing in the potential for id the potential to affect all into receiving home health Employees D and E) It 9:30 AM, a bed bath the home of patient 2 tome health aide D. The in private residence and ipital bed located in the interpolation is morbidly able of moving from side ing over. The HHA used water and washcloths | G000121 | All aides will be re-inserviced of proper procedure for bed bath. The agency will ensure all aide comply with professional standards of care. The agency will evaluate staff compliance through weekly random supervisory visits. Aides observed through weekly random supervisory visits. Aides observed following standards of practice for bed baths will have go through re-training before the are allowed to continue to provicare in the pt's home environment. The DON and ADON are responsible for ensuring on-going compliance with this requirement. The age will ensure staff follows standard infection control practices. The deficiency will be corrected by July 13, 14. | es / rved e to hey vide ency ard e |

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

TITLE

012349

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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| AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157631 | | (X2) MU A. BUII B. WIN | LDING | NSTRUCTION 00 | (X3) DATE COMPL 06/13/ | ETED | |
|---|--|--|-------|---------------------|--|------|----------------------------|
| | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE PLATE STREET 10, IN 46902 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| IAU | back, and then the genital area and inner area and we the one clean was used the second second tub which washcloths to rire and repeating the 2. On 6/12/14 at was observed in performed by HI in a private reside hospital bed local The patient is too The HHA washed torso. The HHA washed the legs, the peri area. The front to back and HHA rinsed the 3. The Alternate Employee F escape home visits and 4. The website http://www.nursmidentifies how includes instruct perineal care for not have a perine | then came back to the ent front to back using sheloth. The HHA then washeloth from the h was the dirty as estarting on the inside exprocess. 11:30 AM, a bed bath the home of patient 3 HA E. The patient lives ence and has a single atted in the living room. It is ally dependent for care. The dath of the face, arms and a changed the water, then back, the buttocks, and the HHA washed from a then back to front. The | | TAU | | | DATE |
| | with clean water | at 110 degrees and | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE | | |
|--|--|--|------------|---------------|---|--------|---|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | G | | 06/13/ | 2014 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COMEO | OT LIGNE LIENT TH | | | | PLATE STREET | | |
| | RT HOME HEALTH | LLC | | KUKUN | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | ΓE | COMPLETION DATE |
| IAG | | dry the rectal area." The | + | IAG | | | DATE |
| | · | ide specific instructions | | | | | |
| | | • | | | | | |
| | on how to wash the perineal area before the rectal area which is different for men | | | | | | |
| | and women. | men is different for men | | | | | |
| | and women. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| 0000450 | 404.40 | | | | | | |
| G000158 | 484.18 ACCEPTANCE OF | F PATIENTS, POC, MED | | | | | |
| | SUPER | TATIENTO, TOO, MED | | | | | |
| | Care follows a written plan of care established and periodically reviewed by a | | | | | | |
| | | | | | | | |
| | medicine. | e, osteopathy, or podiatric | | | | | |
| | | ew and review of clinical | G00 | 00158 | G158/N522- The agency will ensure | | 07/13/2014 |
| | | cy, the agency failed to | | | that all active patient charts will be | | 0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| | - | al care provided to the | | | reviewed by DON, ADON or QI | | |
| | | the medical plan of care | | | Manager for MD notification of POC | | |
| | • | the physician and the | | | by SN and/or therapists. If the review shows the MD was not | | |
| | - | ian was consulted and | | | contacted by being documented on | | |
| | orders were obta | | | | page 1 of the disciplines careplan, | | |
| | | led care, and documented | | | then the MD will be contacted by | | |
| | for all skilled car | | | | phone by 7-11-14 and a clarification | | |
| | | provided in 7 of 12 | | | order will be written that the MD | | |
| | | reviewed (1, 2, 5, 9, 10, | | | was contacted regarding the development of the POC. This will be | ا ا | |
| | | the potential to effect all | | | monitored ongoing on every new | - | |
| | current 150 patie | • | | | admit and recert by the DON and/or | • | |
| | 1 | | | | ADON with review of paperwork as | | |
| | Findings: | | | | it is turned in. The DON and ADON | | |
| | C | | | | will be responsible for orientation | | |
| | 1. On 6/11/14 at | : 1:20 PM, a co-owner, | | | and education of staff. 20% of charts will be audited by the QI manager | غ | |
| | | icated the agency used at | | | for the next two months to ensure | | |
| | | re programs for the | | | orders are present to meet | | |
| | | records, one specifically | | | regulations for the medical plan of | | |
| | | - • | 1 | | | l. | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | |
|--|--|------------------------------|------------|------------|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIII | LDING | 00 | COMPLETED |
| | | 157631 | B. WIN | | | 06/13/2014 |
| | | | Б. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | PROVIDER OR SUPPLIER | | | | PLATE STREET | |
| COMEO | RT HOME HEALTH | II.C. | | | 10, IN 46902 | |
| | | | | | 10, 114 40002 | ı |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | `` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | , | DATE |
| | for medicare pat | | | | care and then quarterly. The DON, | |
| | specifically for n | nedicaid patients, and | | | ADON, or QI manager will be | |
| | indicated the surveyors would not be | | | | responsible to ensure this deficiency | ′ |
| | granted a read or | nly access to the | | | and the corrective actions are | |
| | | al records; access would | | | completed by July 13, 14. | |
| | be through the staff. | | | | | |
| | be unough the st | | | | | |
| | 2 Climinal mass | ed 12 start of same | | | | |
| | | rd 12, start of care | | | | |
| | • | evidence a plan of care | | | | |
| | signed by the physician at the time of the | | | | | |
| | survey on 6/13/14. A verbal order was | | | | | |
| | obtained 5/19/14 | for Home care | | | | |
| | evaluation and tr | eat skilled nurse 2 times | | | | |
| | a week times 1 v | veek, physical therapy | | | | |
| | | reat and occupational | | | | |
| | | on and treat. The | | | | |
| | | | | | | |
| | physician signed | the verbal order | | | | |
| | 5/27/14. | | | | | |
| | | | | | | |
| | A. The phys | sical therapy evaluation | | | | |
| | was performed 5 | /24/14 with requested | | | | |
| | visits 1 times we | ek times 1 week, 2 times | | | | |
| | | eks, then 1 time for 1 | | | | |
| | | ical therapy form did not | | | | |
| | 1 2 | sician had been notified | | | | |
| | | n had not signed the | | | | |
| | | _ | | | | |
| | physical therapy | order for visits. | | | | |
| | | | | | | |
| | | pation therapy evaluation | | | | |
| | was performed 5 | /20/14 with requested | | | | |
| | visits 2 times we | ek times 2 weeks and 1 | | | | |
| | times a week tim | nes 3 weeks. The | | | | |
| | | rapy form did not | | | | |
| | - | sician had been notified | | | | |
| | muicate the phys | sician nau deen nonneu | | | | İ |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | | |
|---|--|------------------------------|------------|------------|---|--------|------------|
| AND PLAN | OF CORRECTION | | A. BUI | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | | | 06/13/ | /2014 |
| NAME OF I | PROVIDER OR SUPPLIER | 1 | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| 0014505 | ST. 110145 11541 TH | | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | KOKON | 1O, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | n had not signed the | | | | | |
| | occupational the | rapy order for visits. | | | | | |
| | | | | | | | |
| | | cal record evidenced | | | | | |
| | skilled nurse visits without orders week 3 | | | | | | |
| | on 5/29/14 and week 4 on 6/2/14; | | | | | | |
| | physical therapy visits without orders | | | | | | |
| | week 3 on 5/28/ | 14 and 5/30/14 and week | | | | | |
| | 4 on 6/3/14 and | 6/5/14; and occupational | | | | | |
| | therapy visits without orders week 3 on | | | | | | |
| | 5/27/14 and 5/29/14 and week 4 on | | | | | | |
| | 6/3/14. | | | | | | |
| | | | | | | | |
| | 3. The undated | policy titled "Physician's | | | | | |
| | l ' | ent" number 2.18, stated, | | | | | |
| | | chorizes a plan of | | | | | |
| | | ed by the agency. | | | | | |
| | | rs will be obtained prior | | | | | |
| | | d treatment of the patient. | | | | | |
| | | - | | | | | |
| | | s may be accepted by | | | | | |
| | professional nurs | _ | | | | | |
| | 1 * * | f nurse. They must be | | | | | |
| | • | l within thirty (30) days. | | | | | |
| | | e to be recorded in the | | | | | |
| | patient's clinical | • | | | | | |
| | . ^ | eiving them A | | | | | |
| | physicians plan | of care must include: | | | | | |
| | The type and fre | quency of services | | | | | |
| | needed, medicat | ions, specific orders for | | | | | |
| | frequency or vis | its Any changes to | | | | | |
| | | lan of treatment shall be | | | | | |
| | | attending physician." | | | | | |
| | | | | | | | |
| | | | | | | | |

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| AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157631 | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 06/13 | ETED | |
|---|---|---|---------------------|---|------|----------------------------|
| | F PROVIDER OR SUPPLIEF | | STREET A | ADDRESS, CITY, STATE, ZIP CODE PLATE STREET 10, IN 46902 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | Administration of stated, "Antibiot permitted to give home with know and specific order reaction are proved the nurse should client for any reaminutes after the Document medic charting it in the record, to include dose, route, of time Observe medication result Verify the physical administration. time of the last respectively by the patient of the last respectively by the patient of the last respectively. Client respectively a week for eight to evaluate and the therapy to evaluate and the therapy to evaluate and a verbal order worders on 5/21/1 | rd 1, start of care (SOC) | | | | |

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| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SU | |
|---------------|---|---|--------|---------------|--|--------------|-------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLET | |
| | | 157631 | B. WIN | G | | 06/13/20 | 114 |
| NAME OF P | ROVIDER OR SUPPLIEF | · | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COMEO | | 11.0 | | | PLATE STREET | | |
| | RT HOME HEALTH | | | | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE C | OMPLETION DATE |
| | | , | | | | | |
| | A The | record included a two | | | | | |
| | | ted 5/21/14 which was | | | | | |
| | | yee B. The referral did | | | | | |
| | | rbal order as written on | | | | | |
| | the plan of care. | | | | | | |
| | ine plan of care. | | | | | | |
| | B. A physician order dated 5/23/14, written by employee K, | | | | | | |
| | | | | | | | |
| | indicated a verbal order was obtained | | | | | | |
| | from the attending physician for home | | | | | | |
| | health care evaluate and treat, skilled | | | | | | |
| | | luring week one, and | | | | | |
| | | and occupational | | | | | |
| | | ate and treat the week of | | | | | |
| | May 25, 2014. | ate and treat the week of | | | | | |
| | Way 25, 2014. | | | | | | |
| | C The | record evidenced the | | | | | |
| | | rapist completed an | | | | | |
| | _ | /31/14 and completed | | | | | |
| | | on June 2 and June 4, | | | | | |
| | | d failed to evidence a | | | | | |
| | | for the occupational | | | | | |
| | visits and the ser | - | | | | | |
| | | r | | | | | |
| | 6. Clinical reco | rd # 2, SOC 2/21/14, | | | | | |
| | | cian order dated 4/17/14 | | | | | |
| | | icated the order was for | | | | | |
| | | on for Home Health Care. | | | | | |
| | | | | | | | |
| | | | | | | | |
| | · · | | | | | | |
| | • | · | | | | | |
| | _ | | | | | | |
| | the recertification Skilled nursing was for 9 weeks, aided provided twice a | on for Home Health Care. was ordered once a week e services were to be a week for nine weeks, I and physical therapy | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | (X2) MULTIPLE CO A. BUILDING | ONSTRUCTION 00 | COM | TE SURVEY MPLETED | |
|--|--|--|---------------------|---|-------------------|----------------------------|
| | | 15/631 | B. WING | | | 13/2014 |
| | PROVIDER OR SUPPLIER | | 1815 S | ADDRESS, CITY, STATE, ZIP (PLATE STREET MO, IN 46902 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| | plan of care for the 4/22/14 through the skilled nurse nine weeks, aide for nine weeks, at twice a week for two week for two week for two week for two weeks. B. The physical therapis on 4/15/14, sever of the certification failed to evidence physical therapy date of the physic | record included a medical he certification period 6/20/14 with orders for services once a week for services twice a week obysical therapy services four weeks then once a reks, and occupational reek for two weeks, twice weeks, and once a week record evidenced the st reassessed the patient in days prior to the start on period. The record e an assessment by occurred on or after the cian order to assess dated cord failed to evidence made during week four of period. The record sit was made on May 14, | | | | |
| | any aide visits / s | record failed to evidence services were provided of the certification | | | | |
| | the occupation th | record failed to evidence nerapy services were red. There were no | | | | |

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| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157631 | A. BUII B. WIN | LDING | NSTRUCTION 00 | (X3) DATE COMPL 06/13/ | ETED |
|--------------------------|--|--|-------------------|---------------------|---|------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | b. why | STREET A | DDRESS, CITY, STATE, ZIP CODE PLATE STREET IO, IN 46902 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | occupational visione. | its made during week | | | | | |
| | included a medic certification peri 6/16/14 with ord provide services for 2 weeks, ther week for 7 week body systems, w buttock, cleanse apply alginate ar daily, and wound cleanse with no sponge and wour mmHg, change care included an zosyn 2.25 millig every 8 hours for included a physic for home health written by emplorecord failed to econsulted for wo the IV antibiotic plan of care. A. The comprehensive a completed by enthe visit occurred 9:15 PM, included | ed 5, start of care 4/16/14, cal plan of care for the od 4/16/14 through ers for skilled nursing to 2 hours 4 times a week of 2 hours a day - 3 days a set to assess / evaluate all cound care - right inner with normal saline, and cover with mepilex of care - left inner buttock formal saline, apply black and vacuum at 125 every 3 days. The plan of IV medication order for grams to be administered or six days. The record can order dated 4/16/14 evaluate and treat, every a days and treatment orders and orders as written on the record included a essessment dated 4/16/14, apployee K, that indicated di between 7:15 PM and ed the diagnoses of itis and acute renal | | | | | |

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| | OF CORRECTION OF CORRECTION 157631 | (X2) MULTIPLE CO A. BUILDING B. WING | NSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 06/13/2014 | | |
|--------------------------|---|--|---|---------------------------------------|--|--|
| | PROVIDER OR SUPPLIER | 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 APPROPRI DEFICIENCY) | (X5) COMPLETION DATE | | |
| | failure. The patient had been discharged from the hospital the same day, 4/16/14, assessed to have a peripherally inserted central catheter [PICC] line inserted on 4/9/14 at the left antecubital space, no arm circumference or the length of the tubing exposed was documented, and lack of knowledge related to medication administration was identified and documented. Post operative surgical debridement of wounds during the hospitalization - wound description on the left inner buttock / perineum was 16.5 centimeters (cm) width X 3.3 cm length X 1.8 cm depth, 20 percent eschar and 80 % granulating tissue and the wound on the right inner buttock was 2.4 cm width 0.6 cm length X 0.4 cm depth 15 % slough / eschar and 85 % granulating tissue. Documentation for recent abnormal laboratory results was a hand written arrow downward and "Hgb [hemoglobin]" and "K [potassium]" not value assigned within the assessment nor where the information was obtained. The comprehensive assessment and the clinical record failed to evidence patient / caregiver education, measurement of learning, observation of the caregiver / patient technique, and a return demonstration to measure education administration via PICC and wound care and any further education required with a | | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157631 | | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 06/13/ | ETED | |
|--|---|---|--------|---------------------|---|------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WIN | 1815 S | NDDRESS, CITY, STATE, ZIP CODE PLATE STREET 10, IN 46902 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | patient / caregive completing and | which tasks the nurse | | | | | |
| | patient / caregiver was capable of completing and which tasks the nurse was to complete. B. On a document titled "MCD [Medicaid] Skilled Care Plan / Nursing Visit Note" of the same date, 4/16/14, stated, "Discharge from acute hosp [hospital] with ongoing extensive wound care needs including cont. [continuous] IV [intravenous] therapy - both requiring SN." The documentation indicated the plan was for the skilled nurse to provide services 2 hours 4 times a week for 2 weeks, then 2 hours a day - 3 days a week for 7 weeks, wound care per wound vacuum to be changed every 3 days, a laboratory draw - a basic metabolic profile on 4/18/14, 4/21/14, and 4/23/14, and to maintain PICC per protocol, sterile dressing change every 7 days. The record failed to evidence a physician was consulted and orders received for the plan as written by the RN, prior to implementation. The record failed to evidence a physician order for the IV antibiotics, dose, frequency, begin date, who could / would administer the medication, wound care orders, and orders for follow through on the low hemoglobin and potassium as noted on the comprehensive assessment. | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XOE711 Facility ID: 012349

If continuation sheet

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PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | 00 | (X3) DATE COMPL | | |
|---|--|------------------------------|------------|--------|---|--------|------------|
| MINDIEMIN | or conduction | 157631 | | LDING | | 06/13/ | |
| | | 107001 | B. WIN | | Paragram and the grant control | 00/10/ | 2014 |
| NAME OF P | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | | 10, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCY) | | DATE |
| | | ed nurse visit note dated | | | | | |
| | _ | ed by employee P, a | | | | | |
| | • | l nurse stated, "IV ATB | | | | | |
| | | er order PICC | | | | | |
| | • | oyee C completed a | | | | | |
| | | t at the same time and | | | | | |
| | | Wound Visit Note | | | | | |
| | | h identified the left | | | | | |
| | wound was with | tunneling or | | | | | |
| | undermining, wa | s not specific which, 6.0 | | | | | |
| | centimeters at 11 o'clock, tunneling and | | | | | | |
| | / or undermining | which was not | | | | | |
| | documented on t | he comprehensive | | | | | |
| | assessment, and | documentation the left | | | | | |
| | wound was dress | sed with green foam | | | | | |
| | verse the black f | oam as written on the | | | | | |
| | plan of care prior | r to applying the wound | | | | | |
| | vacuum. The vi | sit note and clinical | | | | | |
| | record failed to | evidence the physician | | | | | |
| | was notified abo | ut the tunneling / | | | | | |
| | undermining and | I the record failed to | | | | | |
| | evidence a physi | cian order for green | | | | | |
| | foam to be used | with the wound vacuum. | | | | | |
| | | d clinical record failed to | | | | | |
| | evidence patient | / caregiver education, | | | | | |
| | measurement of | learning, observation of | | | | | |
| | | nt technique for the PICC | | | | | |
| | | tration, wound care | | | | | |
| | | evel of education, any | | | | | |
| | • | eation needs, and a clear | | | | | |
| | | h tasks the patient / | | | | | |
| | | mpetent to complete. | | | | | |
| | | 1 | | | | | |
| | D. Skill | ed nurse visit note dated | | | | | |

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Event ID:

XOE711 Facility ID: 012349

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PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | | |
|--|---|------------------------------|------------|------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | KOKOM | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | _ | ed by employee C, a RN, | | | | | |
| | | d draw was obtained | | | | | |
| | from the PICC and the PICC line was | | | | | | |
| | flushed and locked with Heparin. The | | | | | | |
| | visit note failed to evidence who | | | | | | |
| | | IV medications, failed | | | | | |
| | | nd assessment, failed to | | | | | |
| | 1 | systems assessment, a | | | | | |
| | | hrough 50 % of the visit | | | | | |
| | _ | tems assessment portion | | | | | |
| | | The visit note indicated | | | | | |
| | the skilled nurse | visit lasted only 1/2 | | | | | |
| | hour. The note a | and record failed to | | | | | |
| | explain why the | 2 hour skilled nurse visit | | | | | |
| | was not complet | ed as ordered or an order | | | | | |
| | to reduce the du | ration of the skilled nurse | | | | | |
| | visits. | | | | | | |
| | | | | | | | |
| | E. Skill | ed nurse visit note dated | | | | | |
| | 4/19/14 complet | ed by employee C stated, | | | | | |
| | "Removed green | foam dressing, cleansed | | | | | |
| | with normal sali | ne, filled with green | | | | | |
| | | umentation failed to | | | | | |
| | evidence an asse | essment of the PICC line, | | | | | |
| | an assessment of | f the right wound, and an | | | | | |
| | | l body systems - the | | | | | |
| | | rse visit note was left | | | | | |
| | - | note indicated the | | | | | |
| | skilled nurse visit lasted only 1 hour. | | | | | | |
| | The note and record failed to explain | | | | | | |
| | | killed nurse visit was not | | | | | |
| | | | | | | | |
| | completed as ordered and failed to evidence an order to reduce the duration | | | | | | |
| | of the skilled nu | | | | | | |
| | or the skined hu | | | | | | |

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Event ID: XOE711 Facility ID: 012349

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PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157631 | | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 06/13/ | ETED | |
|---|--|--|-------|---------------------|---|------|----------------------------|
| NAME OF I | PROVIDER OR SUPPLIEF | | • | | ADDRESS, CITY, STATE, ZIP CODE PLATE STREET | • | |
| COMFO | RT HOME HEALTH | LLC | | | 10, IN 46902 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | 4/21/14 complet to evidence an asbody systems, the blank with a line evidence an asses access, and faile the patient's right indicated the dret the left buttock wacuum was attated failed to evidence was obtained as care. The visit in nurse visit lasted. The note and rewhy the 2 hours completed as ord failed to evidence duration of the second duration duration duration duration duration duration duration durati | ed nurse visit note dated ed by employee C failed seessment of the patient's de portion of the note was edrawn through, failed to essment of the PICC do to assess the wound on the buttock. The note essing to the wound on was changed and wound ched. The visit note de the laboratory draw written on the plan of tote indicated the skilled donly 3/4 of an hour. Cord failed to explain skilled nurse visit was not dered, and the record de an order to reduce the killed nurse visits. Ited nurse visit note dated ded by employee C the wound on the left and und was tunneling or especified] at 11 o' mentation evidenced the owound dressing, applied the wound bed, and to ound vacuum. The visit the skilled nurse visit ur. The note and record why the 2 hour skilled | | | | | |

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Event ID:

XOE711 Facility ID: 012349

If continuation sheet Page 14 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | X3) DATE SURVEY | |
|--|--|--|--------|---------------|--|------------------|---|
| AND PLAN | AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | | LDING | 00 | COMPLETED | |
| | | 157631 | B. WIN | | | 06/13/2014 | |
| NAME OF P | PROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP CODE | | |
| OOMEO | | | | | PLATE STREET | | |
| | RT HOME HEALTH | | | | 1O, IN 46902 | - | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) | |
| PREFIX TAG | `` | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | E COMPLETIO DATE | N |
| 1710 | | ot completed as ordered, | | 1110 | | DATE | |
| | | illed to evidence an order | | | | | |
| | | ration of the skilled nurse | | | | | |
| | visits. | ation of the skinea harse | | | | | |
| | VISIOS. | | | | | | |
| | H. Skill | led nurse visit note dated | | | | | |
| | | ted by employee P, that | | | | | |
| | | wounds were not | | | | | |
| | | the visit and stated, | | | | | |
| | "Assisted patient | - | | | | | |
| | _ | he plan of care indicated | | | | | |
| | | syn was ordered for 6 | | | | | |
| | days beginning 4 | 1/16/14. The record | | | | | |
| | failed to explain | why the patient was | | | | | |
| | _ | biotic on the 7th day | | | | | |
| | following the sta | rt of the antibiotic. The | | | | | |
| | visit note indicat | ed the skilled nurse visit | | | | | |
| | lasted only 1 hou | ir and 5 minutes, the note | | | | | |
| | and record failed | to explain why the 2 | | | | | |
| | hour skilled nurs | e visit was not | | | | | |
| | completed as ord | lered, and the record | | | | | |
| | failed to evidenc | e an order to reduce the | | | | | |
| | duration of the sl | killed nurse visits. | | | | | |
| | | | | | | | |
| | | ed nurse visit note dated | | | | | |
| | , . | ted by employee P, failed | | | | | |
| | | was provided to the | | | | | |
| | · · | ght and an assessment of | | | | | |
| | | only the wound on the left | | | | | |
| | | rithin the notes - noted | | | | | |
| | _ | changed. The visit note | | | | | |
| | | lled nurse visit lasted | | | | | |
| | - | 10 minutes. The record | | | | | |
| | failed to explain | why the 2 hour skilled | | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | INSTRUCTION | (X3) DATE | | |
|--|--|--|------------|---------------|--|--------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | G | | 06/13/ | 2014 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COMEO | RT HOME HEALTH | II.C | | | PLATE STREET 10, IN 46902 | | |
| | | | | l | 10, 111 40902 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| TAG | | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | COMPLETION DATE |
| 1.10 | | ot completed as written | | 0 | | | 5.112 |
| | on the plan of ca | _ | | | | | |
| | on the plan of ea | | | | | | |
| | J Skille | ed nurse visit note dated | | | | | |
| | | ted by employee P, failed | | | | | |
| | - | was provided to the | | | | | |
| | | ght and an assessment of | | | | | |
| | · | ly the wound on the left | | | | | |
| | · · · · · · · · · · · · · · · · · · · | rithin the notes which | | | | | |
| | | ig was changed. The | | | | | |
| | | ed the skilled nurse visit | | | | | |
| | | ar and 40 minutes. The | | | | | |
| | | explain why the 2 hour | | | | | |
| | | it was not completed as | | | | | |
| | written on the pl | • | | | | | |
| | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | |
| | | ed nurse visit note dated | | | | | |
| | 4/29/14, complet | ted by employee P, | | | | | |
| | evidenced the wo | ound on the right buttock | | | | | |
| | was healed and t | he wound on the left was | | | | | |
| | now 17.0 centim | eters in length X 4.0 cm | | | | | |
| | _ | was documented and | | | | | |
| | | unneling [not specified] | | | | | |
| | was measured to | be 6.0 cm at 11 o'clock, | | | | | |
| | and a blood seru | m sample was collected | | | | | |
| | from the PICC. | | | | | | |
| | | wound on the left was | | | | | |
| | ^ | en foam and not the black | | | | | |
| | | on the plan of care. The | | | | | |
| | | ed the skilled nurse visit | | | | | |
| | | ar and 10 minutes, the | | | | | |
| | | failed to explain why the | | | | | |
| | 2 hour skilled nu | | | | | | |
| | completed as ord | lered, and failed to | | | | | |

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Event ID:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | | ULTIPLE CO LDING | NSTRUCTION 00 | (X3) DATE COMPI 06/13 | LETED | |
|--|----------------------|--|---------------------|---------------|--|-------|------------|
| | | 157651 | B. WIN | | | 00/13 | 72014 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COMEO | | | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | KOKOW | 1O, IN 46902 | | |
| (X4) ID | | FATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTIO | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) | | COMPLETION |
| TAG | | , | | TAG | BEFFERET | | DATE |
| | | er to reduce the duration | | | | | |
| | of the skilled nur | rse visits. | | | | | |
| | T 01.31 | | | | | | |
| | | ed nurse visit note dated | | | | | |
| | | d by employee P, | | | | | |
| | | ing change to the wound | | | | | |
| | | ompleted and green foam | | | | | |
| | _ | e wound bed, not the | | | | | |
| | black foam as w | ritten on the plan of care. | | | | | |
| | | | | | | | |
| | · · · | led nurse visit note dated | | | | | |
| | 5/3/14, complete | d by employee P and | | | | | |
| | indicated a dress | ing change to the wound | | | | | |
| | on the left was c | ompleted and green foam | | | | | |
| | was placed in the | e wound bed, not the | | | | | |
| | black foam as w | ritten on the plan of care. | | | | | |
| | | | | | | | |
| | N. Skill | ed nurse visit note dated | | | | | |
| | 5/7/14, complete | d by employee C stated, | | | | | |
| | "Patient released | from overnight stay at | | | | | |
| | hospital 5/6/14 to | o have abscess I & D | | | | | |
| | _ | inage]. New wound and | | | | | |
| | IV antibiotics." | | | | | | |
| | evidenced the wo | ound on the left buttock | | | | | |
| | was 14.0 cm lens | gth X 3.5 cm width X 0.3 | | | | | |
| | | e wound on the right was | | | | | |
| | _ | 1.5 cm length X 1.75 cm | | | | | |
| | | rd included a Physician | | | | | |
| | _ | greens Infusion that listed | | | | | |
| | l ' | Invanz 1 gram / 100 mL | | | | | |
| | | ne] Mini Bag Plus" and | | | | | |
| | _ | were to "Activate bag as | | | | | |
| | | each dose to dissolve | | | | | |
| | _ | infuse Invanz 1 GM / | | | | | |
| | completely, then | miuse mvanz i Givi / | | | | | |

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| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY |
|-----------|--|------------------------------|--------|------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIII | LDING | 00 | COMPL | ETED |
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | E . | | 1815 S | PLATE STREET | | |
| | RT HOME HEALTH | | _ | | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCE | | DATE |
| | | nour (100 mL / hr) once | | | | | |
| | | per PICC line via gravity | | | | | |
| | set X 7 days." The documentation for the | | | | | | |
| | skilled nurse visit failed to evidence a full | | | | | | |
| | body systems assessment and an | | | | | | |
| | assessment of the PICC line was | | | | | | |
| | completed during the visit. The note | | | | | | |
| | stated, "Instructe | ed on new antibiotic." | | | | | |
| | The record failed | d to evidence orders for | | | | | |
| | the new wound b | peds or that the attending | | | | | |
| | physician was co | onsulted regarding the | | | | | |
| | | c orders and wound care. | | | | | |
| | | | | | | | |
| | O. Skill | led nurse visit note dated | | | | | |
| | | the wound of the left | | | | | |
| | | insed and green foam was | | | | | |
| | | ound bed and vacuum | | | | | |
| | | ound on the right buttock | | | | | |
| | | th normal saline and a | | | | | |
| | | | | | | | |
| | - | ing was applied. The | | | | | |
| | | evidence a physician | | | | | |
| | order for the wor | und care provided. | | | | | |
| | P. Skill | ed nurse visit note dated | | | | | |
| | 5/10/14 indicated | d the wound of the left | | | | | |
| | | insed and green foam was | | | | | |
| | | ound bed and vacuum | | | | | |
| | | ound on the right buttock | | | | | |
| | | th normal saline and a | | | | | |
| | | ing was applied. The | | | | | |
| | _ | evidence a physician | | | | | |
| | | | | | | | |
| | order for the Wo | und care provided. | | | | | |
| | Q. The | record failed to evidence | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE | SURVEY | |
|--|---|------------------------------|------------|-------------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | ETED |
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| NAME OF I | DROWNER OR GURRI IEE | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | X. | | 1815 S | PLATE STREET | | |
| | RT HOME HEALTH | | | | лО, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCE) | | DATE |
| | | dressing was changed | | | | | |
| | during week four of the certification | | | | | | |
| | period. Skilled nurse visits were | | | | | | |
| | completed on May 7, 8, and 10, 2014. | | | | | | |
| | The documentation from these visits | | | | | | |
| | failed to evidence an assessment of the | | | | | | |
| | | l a dressing change. The | | | | | |
| | | evidence an order to | | | | | |
| | disregard the pla | n of care order for | | | | | |
| | weekly dressing | changes to the PICC | | | | | |
| | access. | | | | | | |
| | | | | | | | |
| | 8. Clinical recor | rd #9, start of care (| | | | | |
| | | ncluded the signature of | | | | | |
| | | the referral form, and a | | | | | |
| | | ed 5/14/14 that evidenced | | | | | |
| | | eived an order from the | | | | | |
| | | evaluation and treatment | | | | | |
| | | therapy and physical | | | | | |
| | therapy. | incrapy and physical | | | | | |
| | merapy. | | | | | | |
| | A Th. | record evidenced | | | | | |
| | | | | | | | |
| | employee H con | | | | | | |
| | | assessment on 5/15/14 | | | | | |
| | and employee L | - | | | | | |
| | • | rapy assessment on | | | | | |
| | _ | an of care for the | | | | | |
| | _ | od 5/15/14 through | | | | | |
| | 7/13/14 signed by employee B on 5/12/14 | | | | | | |
| | included orders for physical therapy once | | | | | | |
| | a week for the fi | rst week and twice a | | | | | |
| | week for the following four weeks and | | | | | | |
| | occupational the | rapy twice a week for | | | | | |
| | _ | hen once a week during | | | | | |
| | l | | | | | | |

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Event ID: XOE711 Facility ID: 012349

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | (X2) MU A. BUII | | NSTRUCTION 00 | (X3) DATE COMPI | LETED | |
|--|--|--|--------|---------------------|--|-------|----------------------------|
| | | 157631 | B. WIN | | | | /2014 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | .DDRESS, CITY, STATE, ZIP COD PLATE STREET | E | |
| COMFOR | RT HOME HEALTH | LLC | | KOKOM | IO, IN 46902 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| | week three. | | | | | | |
| | B. On 6 employee K indi the referral and verified the physics she intended to comprehensive at the evidence the attention of the evidence the attention of the evidence that agency be identified in the assessment and the interventions, an plan of care. 9. Clinical recommended the med 3/17/14 through skilled nurse two and once a week services twice at once a week for physical therapy weeks and once and once during therapy twice a very beginning weeks. | clinical record failed to nding physician was lers to admit to the home sed on the needs comprehensive | | | | | |
| | period, one speed | of the certification ch therapy visit was were made during week | | | | | |

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Event ID:

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If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|------------------------------|--------|--------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | Δ RIII | LDING | 00 | COMPL | ETED |
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| C. C | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIER | L | | 1815 S | PLATE STREET | | |
| | RT HOME HEALTH | LLC | | KOKOM | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCE | | DATE |
| | three, and one during week seven. | | | | | | |
| | | | | | | | |
| | 10. Clinical record # 11, start of care | | | | | | |
| | 3/3/14, included a medical plan of care for the certification period 3/3/14 through | | | | | | |
| | | | | | | | |
| | 5/1/14 with orde | rs for skilled nurse visits | | | | | |
| | once a week for | eight weeks and Physical | | | | | |
| | Therapy (PT) an | d Occupational Therapy | | | | | |
| | (OT) to evaluate | and treat. | | | | | |
| | | | | | | | |
| | A. The | record evidence the | | | | | |
| | skilled nurse cor | npleted the | | | | | |
| | | assessment on 3/3/14, the | | | | | |
| | - | e their evaluation and | | | | | |
| | • | 3/5/14, and the OT | | | | | |
| | • | evaluation and began | | | | | |
| | | /14. The record failed to | | | | | |
| | | ending physician was | | | | | |
| | | ing the development of | | | | | |
| | _ | of care based on the | | | | | |
| | needs identified | | | | | | |
| | | _ | | | | | |
| | - | and therapy assessment | | | | | |
| | and treatment or | ders received. | | | | | |
| | R The | record evidenced a | | | | | |
| | | dated 5/1/14 to complete | | | | | |
| | ' | or the home health | | | | | |
| | | | | | | | |
| | · · | rse services once a week | | | | | |
| | _ | begriming May 4, 2014. | | | | | |
| | | , "Area 5 non-skilled | | | | | |
| | _ | lth aide]" to begin week | | | | | |
| | 1 | for two hours, five days a | | | | | |
| | week, for eight v | veeks. A re-assessment | | | | | |
| | was conducted o | n 5/1/14 by a registered | | | | | |

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PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | | |
|---|-------------------------------------|------------------------------|---------------------|------------|---|--------|------------|
| AND PLAN | OF CORRECTION | | A. BUI | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | G | | 06/13/ | /2014 |
| NAME OF I | PROVIDER OR SUPPLIER | 1 | | | DDRESS, CITY, STATE, ZIP CODE | | |
| 0014505 | ST. 1. ON 45 1. 15 4.1 T. 1 | | 1815 S PLATE STREET | | | | |
| COMFOR | RT HOME HEALTH | LLC | | KUKUN | 1O, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE. | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | | DATE |
| | | ntified the patient | | | | | |
| | | e a decubitus present and | | | | | |
| | a follow up plan | | | | | | |
| | certification period 5/2/14 through | | | | | | |
| | | eloped with orders for | | | | | |
| | | veekly. The plan of care | | | | | |
| | | the aide services. The | | | | | |
| | | evidence the agency | | | | | |
| | | ne attending physician to | | | | | |
| | develop of the m | nedical plan of care based | | | | | |
| | on he findings of | f the comprehensive | | | | | |
| | assessment and | failed to evidence aide | | | | | |
| | services were pr | ovided as noted on the | | | | | |
| | 5/1/14 order. | | | | | | |
| | | | | | | | |
| | 11. On 6/12/14 | at 2:08 PM, employee A | | | | | |
| | indicated, when | asked, the referral is | | | | | |
| | obtained from th | e office nurse and that | | | | | |
| | each discipline v | vas to write the name of | | | | | |
| | the attending on | the assessment which | | | | | |
| | was to prove the | y contacted the attending | | | | | |
| | physician for tre | - | | | | | |
| | | | | | | | |
| | 12. On 6/12/14 | at 1:15 PM, employee O | | | | | |
| | | e only places the name of | | | | | |
| | | the form but he does not | | | | | |
| | | ician for treatment orders | | | | | |
| | 1 , | ce staff obtained the | | | | | |
| | | . When asked to clarify, | | | | | |
| | | cated he / she was | | | | | |
| | | nitial order obtained for | | | | | |
| | the evaluation of | | | | | | |
| | and evaluation of | the puttent. | | | | | |
| | 13 During a fac | ea to face interview on | | | | | |
| | 13. During a lac | ee to face interview on | | | | | |

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PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 06/13/ | ETED | |
|--|---|--|--------|----------------|---|----------|----------------------|
| | PROVIDER OR SUPPLIER | | B. WIN | 1815 S | DDRESS, CITY, STATE, ZIP CODE PLATE STREET IO, IN 46902 | . | |
| | SUMMARY S' (EACH DEFICIEN REGULATORY OR 6/13/14 at 10:00 indicated he / she comprehensive a patients for home she indicated the orders and the nu call for physician patient unless the question. He/ sh clinician writes t physician on the is only referring evaluate the paties services and is nu contacted the phy orders and for in of the plan of can 14. During a tele 6/13/14 at 12:30 | AM, employee M, e completed essessments and admitted es health services. He / e office staff obtain the arse in the field does not n orders to treat the ere was a concern or e indicated when the he name of the attending assessment document it to the initial order to ent for home health ot indicating the disciple ysician for treatment put in the development | B. WIN | 1815 S | PLATE STREET | ATE | (X5) COMPLETION DATE |
| | completed by off employee F. Wh the physician for employee N indi- call the physician after completing assessment. He of care is written physician and if | the health services was a fice nurse named then asked if he / she calls initial treatment orders, cated he / she does not an for treatment orders the comprehensive / she indicated the plan and sent to the the physician wishes to she then they may at that | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SUR | | |
|--|----------------------|---|------------|---|--|-------------------------|-----------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLETED 06/13/2014 | |
| | | 157631 | B. WIN | | | 00/13/20 | 14 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COMFOR | RT HOME HEALTH | LLC | | | PLATE STREET 10, IN 46902 | | |
| (X4) ID | SUMMARY ST | FATEMENT OF DEFICIENCIES | | ID PROVIDER'S PLAN OF CORRECT PROFILE ACTION SHOULD | | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | TE C | OMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCY) | | DATE |
| | | at 3:32 PM, employee A | | | | | |
| | | cess for missed visit | | | | | |
| | | notification was when the office staff find | | | | | |
| | | nissed, they write on a | | | | | |
| | | fidential Fax Missed | | | | | |
| | * * | re Patient" that the visit | | | | | |
| | | then the physician was | | | | | |
| | • | ng the form to the | | | | | |
| | | ndicated the physician is | | | | | |
| | | the discipline prior to | | | | | |
| | | visit. She indicated the | | | | | |
| | | t was to notify the | | | | | |
| | physician of the | missed visit. | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| G000159 | 484.18(a) | | | | | | |
| | PLAN OF CARE | eveloped in consultation | | | | | |
| | • | aff covers all pertinent | | | | | |
| | | ng mental status, types of | | | | | |
| | services and equip | oment required, frequency | | | | | |
| | | s, rehabilitation potential, | | | | | |
| | | ns, activities permitted, nents, medications and | | | | | |
| | | ifety measures to protect | | | | | |
| | against injury, inst | | | | | | |
| | discharge or referr | _ | | | | | |
| | appropriate items. | | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MU | JLTIPLE CC | ONSTRUCTION | (X3) DATE SU | RVEY |
|--|---------------------|------------------------------|---------|------------|---|--------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPLET | ED |
| | | 157631 | B. WIN | | | 06/13/20 |)14 |
| | | | D. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | PLATE STREET | | |
| COMEO | RT HOME HEALTH | LLC | | | /IO, IN 46902 | | |
| | | | | KOKOK | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | * | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE C | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | Based on clinical | l record and policy | G00 | 0159 | G159/N524-100% of all active | 0 | 07/13/2014 |
| | review and interv | view, the agency failed to | | | patients were reviewed by the QI | | |
| | ensure the plan of | of care covered all safety | | | manager. A process was developed | | |
| | - | is an accurate plan of | | | and each active chart was reviewed | | |
| | | e "Do Not Resuscitate" | | | to ensure the DNR status was | | |
| | | | | | correct. Any chart found that did no | t | |
| | | 6 home visit patients | | | have correct DNR/Code status was | | |
| | • • | ential for patient harm | | | corrected by writing an MD order of | | |
| | • | nd the ability to affect all | | | clarification. A list of active patients | | |
| | the patients with | advance directives and | | | was compiled to track the audit and | | |
| | failed to ensure t | he plan of care was | | | ensure correct code status. This has | | |
| | | ysician familiar with the | | | been completed as of July 7, 14. The | | |
| | | 2 records reviewed (#6) | | | DON and ADON will be responsible for orientation and education of | | |
| | • | · / | | | staff. 20% of charts will be audited | | |
| | with the potentia | l for patient harm. | | | by the QI manager for the next two | | |
| | | | | | months to ensure orders are presen | + | |
| | Findings: | | | | to meet regulations for the medical | | |
| | | | | | plan of care and then quarterly. The | | |
| | 1. Clinical recor | d 10 evidenced | | | DON, ADON, or QI manager will be | | |
| | physician orders | for the certification | | | responsible to ensure this deficiency | , | |
| | | nrough 5/15/14. The | | | and the corrective actions are | | |
| | - | did not evidence a "Do | | | completed by July 13, 14. | | |
| | | | | | | | |
| | | order. The principal | | | | | |
| | diagnosis listed v | was Attention to | | | | | |
| | Gastrostomy. | | | | | | |
| | | | | | | | |
| | A. A 2010 S | Smart Scribe Medical | | | | | |
| | POC (Plan of Ca | re)/485 Worksheet CM- | | | | | |
| | ` | completed by registered | | | | | |
| | | ployee G, indicated both | | | | | |
| | | d Do not resuscitate had | | | | | |
| | | | | | | | |
| | | t a later date the Do not | | | | | |
| | resuscitate had b | een errored out by | | | | | |
| | Employee G. A | date was not present on | | | | | |
| | the error out. | | | | | | |
| | | | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | INSTRUCTION 00 | (X3) DATE SURVEY COMPLETED | |
|--|----------------------|---|------------------|----------------|---|------------|
| | | 157631 | A. BUI B. WIN | LDING G | | 06/13/2014 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| COMFO | RT HOME HEALTH | IIC | | | PLATE STREET 10, IN 46902 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ı | ID | | (X5) |
| PREFIX | | ICY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE |
| | | sician orders for the | | | | |
| certification period 5/16/14 through 7/14/14 states, "CODE STATUS: Do not | | | | | | |
| | | e principal diagnosis is | | | | |
| | Dysphagia and o | | | | | |
| | | | | | | |
| | | ne Health Aide | | | | |
| | _ | et dated 3/17/14 and | | | | |
| | | t have a place to mark a ent is to be resuscitated, | | | | |
| | _ | to make their own | | | | |
| | decision. | | | | | |
| | | | | | | |
| | | /14 at 5:30 PM, the | | | | |
| | | therapist (ST), Employee | | | | |
| | | patient and re-certified use "Patient demonstrates | | | | |
| | _ | ngeal dysphasia resulting | | | | |
| | | g by mouth) status. " | | | | |
| | | , , | | | | |
| | | 14 at 11:10 AM, | | | | |
| | | or of Nursing, Employee | | | | |
| | 1 | ding error had been | | | | |
| | | Do Not Resuscitate on Care. The software | | | | |
| | company picked | | | | | |
| | | ng. The physician signed | | | | |
| | | a Do Not Resuscitate. | | | | |
| | _ | ally a full code. Staff | | | | |
| | | to the home from | | | | |
| | · | y (6/13/14) under the | | | | |
| | | atient was a Do Not | | | | |
| | Resuscitate. | | | | | |
| | | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY |
|--|----------------------|------------------------------|---------|------------|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BUI | LDING | 00 | COMPLETED |
| | | 157631 | B. WIN | | | 06/13/2014 |
| | | | p. 1111 | | DDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | PROVIDER OR SUPPLIER | L | | | PLATE STREET | |
| COMFOR | RT HOME HEALTH | LLC | | | 10, IN 46902 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE |
| | | ited policy titled "Do Not | | | | |
| | Resuscitate Statu | ıs" stated, "A written | | | | |
| | DNR order will | be issued by the patient's | | | | |
| | primary physicia | ın (if DNR order | | | | |
| | originated during | g the patient's hospital | | | | |
| | | r must be obtained for | | | | |
| | use by the home | | | | | |
| | | U U | | | | |
| | 2. Clinical recor | d 6 evidenced a | | | | |
| | prescription writ | ten by an orthopedic | | | | |
| | | ated 5/13/14. The | | | | |
| | | ered Lovanox [short term | | | | |
| | | t to prevent clotting 40 | | | | |
| | | utaneous for 10 days, | | | | |
| | _ | | | | | |
| | | urgery] P.T [physical | | | | |
| | | TTWB [toe touch weight | | | | |
| | I | er extremity, hip | | | | |
| | l * | ot complainant with | | | | |
| | 1 ~ ~ | estriction, bed to chair | | | | |
| | transfers only, da | aily dressing changes, left | | | | |
| | hip with foam ta | pe." | | | | |
| | | | | | | |
| | | record included a plan of | | | | |
| | care for the certi | fication period 5/15/14 | | | | |
| | through 7/13/14, | start of care 5/15/14, | | | | |
| | contained two si | gnatures on the plan of | | | | |
| | | attending listed on the | | | | |
| | | the name of the nurse | | | | |
| | _ | m signed the plan of | | | | |
| | l ~ | of care failed to include | | | | |
| | the directions red | | | | | |
| | | cian and the lovenox. | | | | |
| | ormopeute physi | erun und me tovellor. | | | | |
| | B. A teleph | one interview with a | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MI | JLTIPLE CO | NSTRUCTION | (X3) DATE S | | |
|--|--|--|------------|---------------|---|--------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | |
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COMFOR | RT HOME HEALTH | LLC | | | PLATE STREET IO, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | CY MUST BE PRECEDED BY FULL I SC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION DATE |
| G000160 | PLAN OF CARE If a physician refers a patient under a plan of | | | | | | |
| | care that cannot be evaluation visit, the approve additions original plan. Based on clinical interview, the agricular was considered additions or moderate in 2 of 6 clinical receiving. The findings incompatible of the certification of the certification of the certification. | e completed until after an e physician is consulted to or modification to the I record review and ency failed to ensure the onsulted to approve lifications to the plan of nical records reviewed of g therapy. (1 and 6) | G00 | 0160 | G160- Staff was given a plan of correction inservice notice that instructed them on contacting the MD with POC orders/modifications/additions. The disciplines were also told verbally of this need. The agency will ensure that all active charts will be reviewed by DON, ADON, or QI Manager for MD notification of POC by SN and/or therapists. If the review shows the MD was not contacted by being documented on page 1 of the disciplines careplan, then the MD will be contacted by phone by 7-11-14 and a clarification | | 07/13/2014 |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|--|-------------------------------|------------------------------|--------|------------|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | , DITT | DDIC | 00 | COMPLETED |
| | | 157631 | | LDING | | 06/13/2014 |
| | | | B. WIN | | ADDRESS CITY STATE ZID CODE | |
| NAME OF P | ROVIDER OR SUPPLIER | 8 | | 1 | ADDRESS, CITY, STATE, ZIP CODE | |
| COMEO | | 11.0 | | | PLATE STREET | |
| COMFOR | RT HOME HEALTH | LLC | | KUKUN | MO, IN 46902 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE |
| | the certification | period. The clinical | | | order will be written that the MD | |
| | record evidenced | the P.T. evaluation was | | | was contacted regarding the | |
| | | 28/14 and treatments | | | development of the POC. 100% aud | t |
| | _ | n 6/3/14 and 6/6/14. The | | | will be done by 7-11-14. This will be | |
| | • | | | | monitored ongoing on every new | |
| | | niled to evidence specific | | | admit and recert by the DON and/or | • |
| | physician orders | for the treatments. | | | ADON with review of paperwork as | |
| | | | | | it is turned in. The DON and ADON | |
| | 2. Clinical record | d 6 evidenced a | | | will be responsible for orientation | |
| | prescription, wri | tten by an orthopedic | | | and education of staff. 20% of chart | S |
| | | ated 5/13/14, that ordered | | | will be audited by the QI manager | |
| | | term use, subcutaneous | | | for the next two months to ensure | |
| | - | <i>'</i> | | | orders are present to meet | |
| | | pagulant to prevent | | | regulations for the medical plan of | |
| | | igrams subcutaneous for | | | care and then quarterly. The DON, | |
| | 10 days, "post o _l | [after surgery] P.T.: | | | ADON, or QI manager will be | |
| | Strict TTWB [to | e touch weight bearing] | | | responsible to ensure this deficiency | ′ |
| | left lower extren | nity, hip precautions, if | | | and the corrective actions are | |
| | | with weight bearing | | | completed by July 13, 14. | |
| | _ | o chair transfers only, | | | | |
| | · · | • | | | | |
| | | nanges, left hip with foam | | | | |
| | tape." | | | | | |
| | | | | | | |
| | A. The recor | rd included a verbal order | | | | |
| | written by emplo | oyee N and dated 5/15/14 | | | | |
| | | ealth Care Services, | | | | |
| | · · | O W [every other week] | | | | |
| | ` | | | | | |
| | | v 1 [home health aide | | | | |
| | one to three hour | rs three days a week for | | | | |
| | one week.] PT E | val and Treat." | | | | |
| | | | | | | |
| | B. The con | nprehensive assessment | | | | |
| | | on 5/15/14 by employee | | | | |
| | _ | | | | | |
| | | dence an attending | | | | |
| | | ontacted for care and | | | | |
| | treatment orders | | | | | |

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Event ID:

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PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157631 | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 06/13/ | ETED |
|--------------------------|--|--|---|---------------------|---|------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | • | 1815 S | ODDRESS, CITY, STATE, ZIP CODE PLATE STREET IO, IN 46902 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | 6/13/14 at 12:30 indicated the initial evaluate for home completed by of When asked if he for initial treatment indicated that he physician for treatments of the physician for treatment to the physician to the physician that times typically works to change may at that times typically works to physician the patternated the patient facility or hospit. D. The reconstruction of the reatment of the attending the physician the patient facility or hospit. E. On 6/12/O indicated he / of the attending not contact the property of the physician the patient of the attending of the attend | ssessment. He / she n of care is written and cian and if the physician the orders then they She indicated she from the orders from the tient most recently nt, from an extended care al. rd evidenced the physical ted the evaluation on tments were provided on 29 and June 3 and 5, al record failed to | | | | | |

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Event ID:

XOE711 Facility ID: 012349

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PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | A. BUII | LDING | NSTRUCTION 00 | (X3) DATE COMPI 06/13 | | |
|--|---|--|--------|---------------|---|---------|--------------------|
| | | 137031 | B. WIN | | | | 72014 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP CODE PLATE STREET | i. | |
| COMFOR | RT HOME HEALTH | HC | | | 10, IN 46902 | | |
| (X4) ID | | FATEMENT OF DEFICIENCIES | | ID | | | (V5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL | D BE | (X5) COMPLETION |
| TAG | · · | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPR DEFICIENCY) | OPRIATE | DATE |
| | treatment orders. | When asked to clarify, | | | | | |
| | employee O indi | cated he / she was | | | | | |
| | referring to the initial order obtained for | | | | | | |
| | the evaluation of | the patient. | | | | | |
| | | | | | | | |
| | F. During a | face to face interview on | | | | | |
| | 6/13/14 at 10:00 | AM, employee M, | | | | | |
| | indicated he / she | • | | | | | |
| | - | ssessments and admitted | | | | | |
| | 1 * | e health services. He / | | | | | |
| | | office staff obtain the | | | | | |
| | | irse in the field does not | | | | | |
| | | orders to treat the | | | | | |
| | _ | ere was a concern or | | | | | |
| | - | e indicated when the | | | | | |
| | | he name of the attending | | | | | |
| | | assessment document it | | | | | |
| | 1 | to the initial order to | | | | | |
| | _ | ent for home health | | | | | |
| | | ot indicating the disciple | | | | | |
| | | ysician for treatment put in the development | | | | | |
| | of the plan of car | • • | | | | | |
| | of the plan of car | | | | | | |
| | 3 The undated r | policy titled "Physician's | | | | | |
| | ^ | nt" number 2.18, stated, | | | | | |
| | | horizes a plan of | | | | | |
| | | ed by the agency. | | | | | |
| | | s will be obtained prior | | | | | |
| | | I treatment of the patient. | | | | | |
| | | s may be accepted by | | | | | |
| | professional nurs | 3 1 3 | | | | | |
| | physician or staf | f nurse. They must be | | | | | |
| | signed and dated | within thirty (30) days. | | | | | |

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Event ID:

XOE711 Facility ID: 012349

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MU | LTIPLE CO | NSTRUCTION | (X3) DATE | | | |
|--|--|---|-----------|---------------|---|--------|--------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 00 | COMPL | | |
| | | 157631 | B. WINC | } <u> </u> | | 06/13/ | 2014 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP CODE | | | |
| COMEO | | | | | PLATE STREET | | | |
| | RT HOME HEALTH | LLC | | KUKUW | IO, IN 46902 | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) | |
| PREFIX TAG | ` | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | 1 | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION DATE | |
| G000161 | patient's clinical professional rece physicians plan of The type and free needed, medicati frequency or visit the physician's p | e to be recorded in the record by the siving them A of care must include: quency of services ions, specific orders for its Any changes to lan of treatment shall be attending physician." | | | | | | |
| | Orders for therapy specific procedure used and the amoduration. Based on clinical review, the agend for therapy conta and modalities to amount, frequence 2 records review therapy services cause harm to all therapy services. Findings: 1. Clinical record 5/23/14, included for the certification. | ey, and duration for 2 of ed of patients receiving with the potential to I patients that receive | G00 | 0161 | G161- Therapy staff was given a plar of correction inservice notice that instructed them on contacting the MD with POC orders/modifications/additions. Therapists were also told verbally of this need. The agency will ensure that 100% of active charts will be reviewed by DON, ADON, or QI Manager for MD notification of POC by therapists. If the review shows the MD was not contacted by being documented on page 1 of the therapists careplan, then the MD will be contacted by phone by 7-11-14 and a clarification order will be written that the MD was contacted regarding the | | 07/13/2014 | |

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Event ID:

XOE711 Facility ID: 012349

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY | |
|--|--|--|------------|---------------|---|------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITT | LDING | 00 | COMPL | ETED |
| | | 157631 | B. WIN | | | 06/13/2014 | |
| | | | b. Wilv | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | L | | | PLATE STREET | | |
| COMEO | RT HOME HEALTH | IIC | | | 10, IN 46902 | | |
| | | | | | , | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| PREFIX TAG | ` | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA' | TE | DATE |
| IAU | | · · · · · · · · · · · · · · · · · · · | | TAU | development of the POC. 100% audi | | DATE |
| | ` ′ | e and treat by week 2 of | | | will be done by 7-11-14. This will be | | |
| | | period. The clinical | | | monitored ongoing on every new | | |
| | record evidenced the P.T. evaluation was | | | | admit and recert by the DON and/or | r | |
| | _ | 28/14 and treatments | | | ADON with review of paperwork as | | |
| | were provided or | n 6/3/14 and 6/6/14. The | | | it is turned in. The DON and ADON | | |
| | clinical record fa | ailed to evidence specific | | | will be responsible for orientation | | |
| | physician orders | for the treatments or | | | and education of staff. 20% of chart | s | |
| | specific procedu | res and modalities to be | | | will be audited by the QI manager | | |
| | used and the am | ount, frequency, and | | | for the next two months to ensure | | |
| | duration. | - | | | orders are present to meet | | |
| | | | | | regulations for the medical plan of care and then quarterly. The DON, | | |
| | 2. Clinical record | d 6 evidenced a | | | ADON, or QI manager will be | | |
| | | tten by an orthopedic | | | responsible to ensure this deficiency | , | |
| | | ated 5/13/14, that ordered | | | and the corrective actions are | | |
| | | term use, subcutaneous | | | completed by July 13, 14. | | |
| | - | | | | | | |
| | | pagulant to prevent | | | | | |
| | | igrams subcutaneous for | | | | | |
| | | [after surgery] P.T.: | | | | | |
| | _ | e touch weight bearing] | | | | | |
| | left lower extren | nity, hip precautions, if | | | | | |
| | not complainant | with weight bearing | | | | | |
| | restriction, bed to | o chair transfers only, | | | | | |
| | daily dressing ch | anges, left hip with foam | | | | | |
| | tape." The recor | d evidenced the physical | | | | | |
| | therapist comple | ted the evaluation on | | | | | |
| | | tments were provided on | | | | | |
| | | 29 and June 3 and 5, | | | | | |
| | | al record failed to | | | | | |
| | evidence physici | | | | | | |
| | | ecific procedures and | | | | | |
| | _ | | | | | | |
| | | used and the amount, | | | | | |
| | frequency, and d | uration. | | | | | |
| | | | | | | | |
| | 3. The undated p | policy titled "Physician's | | | | | |

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XOE711 Facility ID: 012349

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | |
|--|--|--|--|--------|--|--------------------------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1815 S PLATE STREET KOKOMO, IN 46902 | | | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| G000168 | Plan Of Treatme "A A physicial include: The type services needed, orders for freque changes to the pl treatment shall b attending physicial 484.30 SKILLED NURSIN Based on clinical review and interview and interview and interview services were proplan of care in 3 | nt" number 2.18, stated, ns plan of care must e and frequency of medications, specific ncy or visits Any nysician's plan of e reviewed by the ian." | G00 | 0168 | All nurses inserviced on how to initiate accurate plan of care covering all aspects of the PO and all requirements of medica plan of care. All staff will be oriented on all aspects of the medical plan of care to include | C al | 07/13/2014 |
| | patients receiving 170), failed to iconcerns in the phome visits obseto ensure the regaccurate plan of reviewed with the harm for this patient affect all the patifailed to ensure the accurately initiated. Resuscitate "state" | g nursing services (See G dentify and address safety patients home in 1 of 6 rved (see G 172), failed istered nurse initiated an care in 2 of 12 records e potential for patient ient and the ability to tents (See G 173), and the registered nurse | | | admission orders and nursing and therapy orders for their caplans. Nursing staff will be educated on all requirements of medical plan of care. Nurses at therapists are to contact MD for orders on their care plan and it to be documented on the first page of the care plan that the was called. The plan of care is sent to the MD for signature and is required to be signed in 30 days per regulations. The physician's signature of the PO is a confirmation that the nurs/therapist received verbal orders regarding conferring on | of and or t is MD and | |

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| i ´ | | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATE SURVEY | | | |
|--------------------------|---|---|--|--|---------------------------------------|--|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED | | |
| | | 157631 | B. WING | | 06/13/2014 | | |
| | PROVIDER OR SUPPLIER | LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 1815 S PLATE STREET KOKOMO, IN 46902 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE | | |
| | affect all the pat directives (See C The cumulative problems resulte inability to prov meet the require | tient and the ability to tients with advance G 175). effect of these systemic and in the agency's tide safe nursing care to ments of the Condition 484.30: Skilled Nursing | | the plan of care. The physician signature is the authorization of MD orders for the POC. The D and ADON will be responsible orientation and education of st 20% of new and current charts will be audited by the QI manafor the next 2 months to ensur orders are present in the chart meet regulations for the medic plan of care and then quarterly. The QI Manager will be responsible for monitoring the corrective actions to ensure the deficiency is corrected by July 14 and will not reoccur. | of DON for taff. s ager e t to cal y. | | |
| G000170 | in accordance with Based on interving records and policensure the nursing as ordered on the clinical records with the potential receiving nursing Findings: | s skilled nursing services in the plan of care. ew and review of clinical cy, the agency failed to ing services were provided e plan of care in 3 of 12 reviewed (1, 5, and 12) | G000170 | G170/N537-100 % of charts will be audited by DON, ADON or QI manager related to MD orders and POC orders/modifications/additions by July 11, 14. Staff was given a plar of correction inservice notice that instructed them on contacting the MD with POC orders/modifications/additions. The disciplines were also told verbally of this need. Disciplines will ensure that they perform care under the MD order. Staff will be educated pe | n e f | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE | | | SURVEY | | |
|--|---------------------------------------|--------------------------------------|---------|--------|--|--------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITE | LDING | 00 | COMPL | ETED |
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| | | | b. Wilv | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIEF | 2 | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | | 10, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | | | (V.5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | ì · | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | DATE |
| 1710 | | o evidence a plan of care | | 1710 | plan of correction inservice notice | | Ditte |
| | | ysician at the time of the | | | on consulting with the MD for every | , | |
| | | • | | | aspect of care to be provided and | | |
| | survey on 6/13/14. A verbal order was | | | | that care cannot deviate from a | | |
| | obtained 5/19/14 for Home care | | | | current order for Tx or meds. A new | , | |
| | | reat skilled nurse 2 times | | | order must be obtained for any | | |
| | a week times 1 v | veek, physical therapy | | | change. The MD will be contacted | | |
| | evaluation and to | reat and occupational | | | for all initial and ongoing treatment | | |
| | therapy evaluation | on and treat. The | | | orders. The DON and ADON will be | | |
| | physician signed | the verbal order | | | responsible for orientation and | | |
| | 5/27/14. The cli | nical record evidenced | | | education of staff. 20% of charts wil | ı | |
| | skilled nurse vis | its without orders week 3 | | | be audited by the QI manager for the next two months to ensure | | |
| | on 5/29/14 and v | veek 4 on 6/2/14. | | | orders are present to meet | | |
| | | | | | regulations for the medical plan of | | |
| | Surveyor: Boston, I | Bridget | | | care and then quarterly. The DON, | | |
| | | | | | ADON, or QI manager will be | | |
| | 2. The undated | policy titled "Medication | | | responsible to ensure this deficiency | У | |
| | Administration (| Guidelines" number 2.57 | | | and the corrective actions are | | |
| | | ics a. Nurses are only | | | completed by July 13, 14. | | |
| | · · | e the initial dose in the | | | | | |
| | ^ ~ | rledge of the physician | | | | | |
| | | ers for treatment of a | | | | | |
| | _ | vided by the physician | | | | | |
| | | | | | | | |
| | | d observe the patient / | | | | | |
| | 1 | action for at least 30 | | | | | |
| | | e dose is given | | | | | |
| | | cation administration by | | | | | |
| | _ | patient / client's clinical | | | | | |
| | record, to includ | e: a. medication name, | | | | | |
| | dose, route, c | . medication date and | | | | | |
| | time Observ | re the patient / client for | | | | | |
| | | ts and document, 1. | | | | | |
| | | cian order for medication | | | | | |
| | | 2. Verify the date and | | | | | |
| | | nedication administration | | | | | |
| | mine of the last I | neareation administration | | | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | (X2) MU A. BUII B. WIN | DING | NSTRUCTION 00 | (X3) DATE COMPL 06/13 / | ETED | |
|---|--|--|--------|---------------------|--|----------|----------------------------|
| | PROVIDER OR SUPPLIEF | | D. WIN | STREET A | DDRESS, CITY, STATE, ZIP CODE PLATE STREET 10, IN 46902 | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | by checking the patient / client re | documentation in the ecord." | | | | | |
| | evidenced a plan certification period 6/11/14 with ord a week for eight signed the plan of indicating a verb these orders on 5 failed to evidence referenced. The page referral dat signed by emplo not include a verb the plan of care. A. A place of 5/23/14, written indicated a verb from the attending health care evaluating one visit decompanies. B. The occupational the assessment on 5/2 additional visits 2014. The recomplysicians order visits and the seriod. | od 5/23/14 through lers for skilled nurse once weeks. Employee B of care dated 5/21/14 val order was received for 6/21/14. The record let the verbal order record included a two led 5/21/14 which was yee B. The referral did lebal order as written on hysician order dated by employee K, let order was obtained leg physician for home late and treat, skilled luring week one. record evidenced the rapist completed an left of the occupational | | | | | |

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| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157631 | LDING | NSTRUCTION 00 | (X3) DATE COMPL 06/13/ | ETED |
|--------------------------|---|---|---------------------|---|------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | 1815 S | ODDRESS, CITY, STATE, ZIP CODE PLATE STREET IO, IN 46902 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | included a medic certification perion 6/16/14 with ord provide services for 2 weeks, ther week for 7 week body systems, we buttock, cleanse apply alginate and daily, and wound releanse with no sponge and wound mmHg, change exare included an zosyn 2.25 millig every 8 hours for failed to evidence consulted for wothe IV antibiotic plan of care. A. Skill 4/17/14 complete licensed practica [antibiotic] ran pflushes." Emploskilled nurse visit | cal plan of care for the od 4/16/14 through ers for skilled nursing to 2 hours 4 times a week a 2 hours a day - 3 days a set to assess / evaluate all ound care - right inner with normal saline, ad cover with mepilex dicare - left inner buttock armal saline, apply black and vacuum at 125 every 3 days. The plan of IV medication order for grams to be administered exist days. The record ea physician was und treatment orders and orders as written on the ed nurse visit note dated ed by employee P, a I nurse stated, "IV ATB er order PICC eyee C completed a t at the same time and Wound Visit Note | | | | |
| | wound was with undermining, wa | s not specific which, 6.0 o'clock, tunneling and | | | | |

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| | OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE COMPL | |
|-----------|----------------------|---|--------|------------|--|--------------------|------------|
| ANDILAN | OF CORRECTION | 157631 | | LDING | 00 | 06/13/ | |
| | | 137031 | B. WIN | | | 00/13/ | 2014 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COMFOR | RT HOME HEALTH | LLC | | | PLATE STREET 10, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | the comprehensive | | | | | |
| | | documentation the left | | | | | |
| | | sed with green foam | | | | | |
| | verse the black f | oam as written on the | | | | | |
| | plan of care prio | r to applying the wound | | | | | |
| | vacuum. The vi | isit note and clinical | | | | | |
| | record failed to | evidence the physician | | | | | |
| | was notified abo | ut the tunneling / | | | | | |
| | undermining and | the record failed to | | | | | |
| | evidence a physi | cian order for green | | | | | |
| | foam to be used | with the wound vacuum. | | | | | |
| | The visit note an | d clinical record failed to | | | | | |
| | evidence patient | / caregiver education, | | | | | |
| | measurement of | learning, observation of | | | | | |
| | caregiver / patier | nt technique for the PICC | | | | | |
| | care, IV adminis | tration, wound care | | | | | |
| | | evel of education, any | | | | | |
| | | cation needs, and a clear | | | | | |
| | | h tasks the patient / | | | | | |
| | | empetent to complete. | | | | | |
| | | 1 | | | | | |
| | B. Skill | ed nurse visit note dated | | | | | |
| | | ed by employee C, a RN, | | | | | |
| | _ | d draw was obtained | | | | | |
| | | nd the PICC line was | | | | | |
| | | ed with Heparin. The | | | | | |
| | visit note failed | 1 | | | | | |
| | | IV medications, failed | | | | | |
| | | nd assessment, failed to | | | | | |
| | | systems assessment, a | | | | | |
| | | hrough 50 % of the visit | | | | | |
| | | tems assessment portion | | | | | |
| | was left blank. | ems assessment portion | | | | | |
| | was icit bialik. | | | | | | |
| | | | | | | | |

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Event ID:

XOE711 Facility ID: 012349

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY | |
|--|----------------------|------------------------------|------------|------------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BIII | LDING | 00 | COMPL | ETED |
| | | 157631 | B. WIN | | | 06/13/ | /2014 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | t . | | 1815 S | PLATE STREET | | |
| | RT HOME HEALTH | | | <u> </u> | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCE) | | DATE |
| | | led nurse visit note dated | | | | | |
| | • | ed by employee C stated, | | | | | |
| | | foam dressing, cleansed | | | | | |
| | | ne, filled with green | | | | | |
| | | umentation failed to | | | | | |
| | | essment of the PICC line, | | | | | |
| | an assessment of | f the right wound, and an | | | | | |
| | | l body systems - the | | | | | |
| | portion of the nu | rse visit note was left | | | | | |
| | blank. | | | | | | |
| | | | | | | | |
| | D. Skil | led nurse visit note dated | | | | | |
| | 4/21/14 complet | ed by employee C failed | | | | | |
| | to evidence an a | ssessment of the patient's | | | | | |
| | body systems, th | e portion of the note was | | | | | |
| | blank with a line | drawn through, failed to | | | | | |
| | evidence an asse | essment of the PICC | | | | | |
| | access, and faile | d to assess the wound on | | | | | |
| | | t buttock The note | | | | | |
| | | essing to the wound on | | | | | |
| | | was changed and wound | | | | | |
| | | ched. The visit note | | | | | |
| | | e the laboratory draw | | | | | |
| | | written on the plan of | | | | | |
| | care. | The plan of | | | | | |
| | Care. | | | | | | |
| | E. Skill | ed nurse visit note dated | | | | | |
| | | ed by employee C | | | | | |
| | • | he wound on the left and | | | | | |
| | I | und was tunneling or | | | | | |
| | | specified] at 11 o' | | | | | |
| | | mentation evidenced the | | | | | |
| | | | | | | | |
| | | wound dressing, applied | | | | | |
| | green toam to th | e wound bed, and | | | | | |

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Event ID: XOE711 Facility ID: 012349

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| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157631 | A. BUII | LDING | NSTRUCTION 00 | (X3) DATE COMPI 06/13 | LETED |
|--------------------------|--|---|---------|---------------------|---|-----------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WIN | STREET A | DDRESS, CITY, STATE, ZIP CODE PLATE STREET IO, IN 46902 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| | 4/23/14, complet documented the assessed during to "Assisted patient [antibiotics]." The antibiotic zoo days beginning 4 failed to explain infusing the antil following the state of the evidence care wound on the rige either wound. Owas addressed with dressing was H. Skill | ed nurse visit note dated and by employee P, that wounds were not the visit and stated, with IV ATB the plan of care indicated syn was ordered for 6 k/16/14. The record why the patient was provided to the antibiotic. ed nurse visit note dated and an assessment of any the wound on the left ithin the notes - noted changed. | | | | | |
| | to evidence care wound on the rig either wound; on | was provided to the that and an assessment of the wound on the left ithin the notes which g was changed. | | | | | |
| | 4/29/14, complet evidenced the wo | ed nurse visit note dated red by employee P, bund on the right buttock the wound on the left was | | | | | |

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Event ID:

XOE711 Facility ID: 012349

If continuation sheet

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| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157631 | A. BUILI | DING | NSTRUCTION 00 | (X3) DATE COMPI 06/13 . | ETED |
|---------------|----------------------------------|--|----------|---------------|---|--------------------------------------|--------------------|
| | | 137031 | B. WING | | | 00/13/ | 2014 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COMEO | RT HOME HEALTH | II.C | | | PLATE STREET 10, IN 46902 | | |
| | | | | | 10, 111 40902 | | |
| (X4) ID | | FATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) | | (X5) |
| PREFIX TAG | , i | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | l I | PREFIX TAG | CROSS-REFERENCED TO THE APPROF | RIATE | COMPLETION DATE |
| 1710 | | eters in length X 4.0 cm | | 1710 | <u> </u> | | DATE |
| | | was documented and | | | | | |
| | - | unneling [not specified] | | | | | |
| | | be 6.0 cm at 11 o'clock, | | | | | |
| | | m sample was collected | | | | | |
| | from the PICC. | | | | | | |
| | | wound on the left was | | | | | |
| | | en foam and not the black | | | | | |
| | l - | on the plan of care. | | | | | |
| | Tourn us written | on the plan of care. | | | | | |
| | J Skille | ed nurse visit note dated | | | | | |
| | | d by employee P, | | | | | |
| | | ing change to the wound | | | | | |
| | | ompleted and green foam | | | | | |
| | | e wound bed, not the | | | | | |
| | _ | ritten on the plan of care. | | | | | |
| | orack rount as wi | then on the plan of care. | | | | | |
| | K. Skill | ed nurse visit note dated | | | | | |
| | 5/3/14, complete | d by employee P and | | | | | |
| | _ | ing change to the wound | | | | | |
| | | ompleted and green foam | | | | | |
| | | e wound bed, not the | | | | | |
| | _ | ritten on the plan of care. | | | | | |
| | | • | | | | | |
| | L. Skill | ed nurse visit note dated | | | | | |
| | 5/7/14, complete | d by employee C stated, | | | | | |
| | "Patient released | from overnight stay at | | | | | |
| | | o have abscess I & D | | | | | |
| | [incision and dra | inage]. New wound and | | | | | |
| | IV antibiotics." | Documentation | | | | | |
| | evidenced the wo | ound on the left buttock | | | | | |
| | was 14.0 cm leng | gth X 3.5 cm width X 0.3 | | | | | |
| | | e wound on the right was | | | | | |
| | 3.0 cm width X | 1.5 cm length X 1.75 cm | | | | | |

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| | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157631 | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 06/13/ | ETED |
|--------------------------|--|---|--------|---------------------|--|------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WIN | 1815 S | DDRESS, CITY, STATE, ZIP CODE PLATE STREET IO, IN 46902 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | Order from Walsthe medication "NS [normal salin the instructions of directed prior to completely, then 100 mL over 1 hevery 24 hours poset X 7 days." To skilled nurse visional body systems as assessment of the completed during stated, "Instructed The record failed the new wound be physician was conew IV antibiotion. M. Skilled S/8/14 indicated buttock was clean applied to the word applied. The word was cleansed with wet to dry dressing record failed to expect order for the word. N. Skilled S/10/14 indicated buttock was cleansed with wet to dry dressing record failed to expect order for the word. | | | | | | |

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Event ID:

XOE711 Facility ID: 012349

If continuation sheet

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| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157631 | (X2) MULTIPLE CO A. BUILDING | ONSTRUCTION 00 | COM | TE SURVEY MPLETED 13/2014 |
|-----------|----------------------------------|--|---------------------------------|--|-------------|---------------------------|
| | | 107001 | B. WING | ADDRESS SITE OF THE SITE OF TH | | 10/2014 |
| NAME OF F | PROVIDER OR SUPPLIER | 8 | | ADDRESS, CITY, STATE, ZIP C PLATE STREET | CODE | |
| COMFOR | RT HOME HEALTH | LLC | | MO, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | T | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | PREFIX | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI | HOULD BE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE A | APPROPRIATE | DATE |
| | applied. The wo | ound on the right buttock | | | | |
| | was cleansed wit | th normal saline and a | | | | |
| | wet to dry dressi | ng was applied. The | | | | |
| | record failed to | evidence a physician | | | | |
| | order for the wor | und care provided. | | | | |
| | | | | | | |
| | O. The | record failed to evidence | | | | |
| | the PICC access | dressing was changed | | | | |
| | _ | r of the certification | | | | |
| | period. Skilled | nurse visits were | | | | |
| | | ay 7, 8, and 10, 2014. | | | | |
| | The documentati | ion from these visits | | | | |
| | failed to evidence | e an assessment of the | | | | |
| | PICC access and | a dressing change. The | | | | |
| | record failed to | evidence an order to | | | | |
| | | n of care order for | | | | |
| | weekly dressing | changes to the PICC | | | | |
| | access. | | | | | |
| | 6. On 6/12/14 | at 2:08 PM, employee A | | | | |
| | | asked, the referral is | | | | |
| | · | e office nurse and that | | | | |
| | | vas to write the name of | | | | |
| | • | the assessment which | | | | |
| | | y contacted the attending | | | | |
| | physician for tre | | | | | |
| | | | | | | |
| | 7. On 6/12/14 at | t 1:15 PM, employee O | | | | |
| | | e only places the name of | | | | |
| | the attending on | the form but he does not | | | | |
| | contact the phys | ician for treatment orders | | | | |
| | and that the office | ce staff obtained the | | | | |
| | treatment orders | . When asked to clarify, | | | | |
| | employee O indi | cated he / she was | | | | |

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| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157631 | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 06/13 / | ETED |
|--------------------------|--|---|---|---------------------|--|--------------------------------------|----------------------------|
| NAME OF F | PROVIDER OR SUPPLIER | | • | | DDRESS, CITY, STATE, ZIP CODE PLATE STREET | • | |
| COMFOR | RT HOME HEALTH | LLC | | KOKOM | 1O, IN 46902 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | referring to the i | nitial order obtained for fthe patient. | | | | | |
| | 6/13/14 at 10:00 indicated he / she comprehensive a patients for hom she indicated the orders and the nu call for physician patient unless the question. He/ she clinician writes the physician on the is only referring evaluate the patiservices and is nu contacted the physician on the physician or the services and is nucontacted the physician of the physician or the physician or the patiservices and is nucontacted the physician of the physician or the physician o | e health services. He / e office staff obtain the arse in the field does not an orders to treat the ere was a concern or the indicated when the the name of the attending assessment document it to the initial order to ent for home health ot indicating the disciple sysician for treatment put in the development | | | | | |
| | 6/13/14 at 12:30 indicated the init evaluate for hom | phone interview on PM, employee N tial physician order to the health services was fice nurse named | | | | | |
| | the physician for employee N indi call the physician after completing | nen asked if he / she calls initial treatment orders, cated he / she does not in for treatment orders the comprehensive / she indicated the plan in and sent to the | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MI | JLTIPLE CO | NSTRUCTION | (X3) DATE | | |
|--|---|---|---------------------------------|--------------|--|--------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 157631 | A. BUILDING 00 COMPLET 06/13/20 | | | | |
| | | 15/651 | B. WIN | | | 06/13/ | 2014 |
| NAME OF F | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COMEO | RT HOME HEALTH | ПС | | | PLATE STREET 10, IN 46902 | | |
| | | | 1 | l | 10, 114 40302 | | |
| (X4) ID PREFIX | | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | `` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | DATE |
| | | the physician wishes to s then they may at that | | | | | |
| G000172 | The registered number based on clinical observation, the the registered ideasafety concerns in of 6 home visits the potential for harm themself. The findings included in the Halone in a ranch paid help during was for physical indicated the pattoilet extension exconnector to the | I record review and agency failed to ensure entified and addressed in the patients home in 1 observed (#1) creating the patient to fall and | G00 | 00172 | G172/N541-100 % of active charts will be reviewed by DON, ADON, or QI Manager to ensure that no safety issue is present in current charts. Education to pt/family/caregiver on safety is to be completed by skilled staff. Staff will be instructed to record safety issues on comprehensive assessment or visit note and will be re-instructed on the incident reporting policy. The DON and/or ADON will instruct the clinical staff on safety issue/incident reporting. The agency will ensure all pts are regularly evaluated and re-evaluated following any incident regarding pt safety, or any health concern. When the agency is aware of a safety concern or incident, an incident report is completed which includes notifying the MD of the incident. Staff are instructed to | | 07/13/2014 |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|--|----------------------|--------------------------------|------------|-------------|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | Δ RIII | LDING | 00 | COMPLETED |
| | | 157631 | B. WIN | | | 06/13/2014 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | PROVIDER OR SUPPLIEF | ₹ | | 1815 S | PLATE STREET | |
| COMFOR | RT HOME HEALTH | LLC | | KOKOM | /IO, IN 46902 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | |
| TAG | | R LSC IDENTIFYING INFORMATION) | | TAG | , | DATE |
| | | illen to one side. The | | | notify the MD. Disciplines ongoing | 4 |
| | _ | ad caught the patient | | | safety assessment is to be addresse on each visit. Ongoing chart audits | u |
| | _ | e floor. The patient did | | | are reviewed with quarterly record | |
| | not appear to be | hurt. The paid attendant | | | review by the QI manager. This will | |
| | had not notified | anyone. The patient had | | | be completed by July 13, 14. | |
| | called a friend to | come and put on | | | | |
| | different handle | es on the toilet. The | | | | |
| | handles attached | l directly to the back of | | | | |
| | the toilet through | h the lid holes. Upon | | | | |
| | inspection, both | the new handles and the | | | | |
| | _ | are loose and tilt from | | | | |
| | side to side. The | e agency nurse stayed in | | | | |
| | | and did not come to the | | | | |
| | _ | e toilet inspection. The | | | | |
| | | st assistant did come in. | | | | |
| | physical therapi | st assistant are come in. | | | | |
| | On 6/11/14 | at 5:15 PM, the physical | | | | |
| | therapist assistar | nt, Employee J, indicated | | | | |
| | the new bars and | d the toilet extension | | | | |
| | were not securel | y attached to the toilet. | | | | |
| | When the patien | it would try to get up and | | | | |
| | | on one side than the | | | | |
| | other, they woul | | | | | |
| | , ., | | | | | |
| , | 2. Clinical reco | ord 1, start of care (SOC) | | | | |
| | evidenced a plan | | | | | |
| | _ | iod 5/23/14 through | | | | |
| | _ | lers for skilled nurse once | | | | |
| | | weeks, physical therapy | | | | |
| | _ | treat, and occupational | | | | |
| | | • | | | | |
| | 1 - | ate and treat by the | | | | |
| | | the record failed to | | | | |
| | 1 | of safety features in the | | | | |
| | patient's bathroo | om and that a plan had | | | | |

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| | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATE SURVEY |
|-----------|------------------------------------|---|-----------------|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | 157631 | B. WING | | 06/13/2014 |
| NAME OF P | ROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP CODE | |
| | | | | PLATE STREET | |
| COMFOR | RT HOME HEALTH | LLC | KOKO | MO, IN 46902 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | - | to prevent and reduce | | | |
| | falls. | | | | |
| | The com | onrahansiya assassment | | | |
| | | aprehensive assessment tient was assessed to be | | | |
| | | ith a score of 11. | | | |
| | | was determined by the | | | |
| | | ent form to be at high risk | | | |
| | for falls. | int form to be at high risk | | | |
| | 101 14115. | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| G000173 | 484.30(a) | | | | |
| 0000170 | | REGISTERED NURSE | | | |
| | • | se initiates the plan of | | | |
| | care and necessar | | | | |
| | | l record and policy | G000173 | G173/N542-100% of all active | 07/13/2014 |
| | | view, the agency failed to | | patients were reviewed by the QI manager. A process was developed | |
| | • | ered nurse initiated an | | and each active chart was reviewed | |
| | • | care in 2 of 12 records | | to ensure the DNR status was | |
| | | e potential for patient | | correct. An active patient list was | |
| | • | ient and the ability to | | compiled to track the audit and | |
| | affect all the pati | ents. (5 and 10) | | ensure correct code status. Any | |
| | | | | chart found that did not have | |
| | Findings: | | | correct DNR/Code status was corrected by writing an MD order of | |
| | | | | clarification. A list was compiled to | |
| | Clinical recor | d 10 evidenced | | track the audit and ensure correct | |
| | physician orders | for the certification | | code status. This has been | |

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| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|-----------|--|------------------------------|-------------------|------------|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DITT | LDING | 00 | COMPLETED |
| | | 157631 | A. BUII B. WIN | | | 06/13/2014 |
| | | | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | PROVIDER OR SUPPLIEF | ₹ | | | PLATE STREET | |
| COMFOR | RT HOME HEALTH | LLC | | | /O, IN 46902 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE |
| | period 3/17/14 tl | hrough 5/15/14. The | | | completed as of July 7, 14. The DON | |
| | physician orders | did not evidence a Do | | | and ADON will be responsible for | |
| | Not Resuscitate | order. The principal | | | orientation and education of staff. | |
| | diagnosis listed | | | | 20% of charts will be audited by the | |
| | | he plan of care indicated | | | QI manager for the next two month | S |
| | _ | a Do Not Resuscitate | | | to ensure orders are present to | |
| | | 1 Do Not Resuscitate | | | meet regulations for the medical plan of care and then quarterly. The | |
| | status. | | | | DON, ADON, or QI manager will be | |
| | | | | | responsible to ensure this deficience | , |
| | | Smart Scribe Medical | | | and the corrective actions are | , |
| | ` | are)/485 Worksheet CM- | | | completed by July 13, 14. | |
| | 3 dated 5/13/14 | completed by registered | | | | |
| | nurse (RN), Emp | ployee G, indicated both | | | | |
| | the Full code and | d Do not resuscitate had | | | | |
| | been marked. A | t a later date the Do not | | | | |
| | resuscitate had b | peen errored out by | | | | |
| | | date was not present on | | | | |
| | the error out. | dute was not present on | | | | |
| | | | | | | |
| | | sician orders for the | | | | |
| | certification peri | iod 5/16/14 through | | | | |
| | 7/14/14 evidence | es "CODE STATUS: Do | | | | |
| | not resuscitate." | | | | | |
| | C The Hon | ne Health Aide | | | | |
| | | et dated 3/17/14 and | | | | |
| | 1 | | | | | |
| | | t have a place to mark a | | | | |
| | | de, leaving the aide to | | | | |
| | make their own | decision. | | | | |
| | D. On 6/13/ | /14 at 11:10 AM, | | | | |
| | Alternate Director of Nursing, Employee F, indicated a coding error had been | | | | | |
| | | | | | | |
| | | Do Not Resuscitate on | | | | |
| | _ | Care. The software | | | | |
| | uie 483/Pian of C | care. The software | | | | |

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Event ID:

XOE711

Facility ID: 012349

If continuation sheet

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PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | NSTRUCTION 00 | (X3) DATE COMPL | | |
|--|----------------------|------------------------------|------------------------|------------------|---|----------|------------|
| | | 157631 | A. BUILDING B. WING | | | 06/13/ | /2014 |
| | | | | EET A | DDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| NAME OF I | PROVIDER OR SUPPLIER | 8 | | | PLATE STREET | | |
| COMFO | RT HOME HEALTH | LLC | | | IO, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREF | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | j | DEFICIENCY) | | DATE |
| | company picked | • | | | | | |
| | | ng. The physician signed | | | | | |
| | | a Do Not Resuscitate. | | | | | |
| | _ | ally a full code. Staff | | | | | |
| | | to the home from | | | | | |
| | l - | y (6/13/14) under the | | | | | |
| | Resuscitate. | atient was a Do Not | | | | | |
| | Resuscitate. | | | | | | |
| | E. The unda | ated policy titled "Do Not | | | | | |
| | | us" stated, "A written | | | | | |
| | | be issued by the patient's | | | | | |
| | | an (if DNR order | | | | | |
| | 1 | g the patient's hospital | | | | | |
| | | r must be obtained for | | | | | |
| | | health agency)." | | | | | |
| | - | C 1 , | | | | | |
| | 2. Clinical recor | rd 5, start of care 4/16/14, | | | | | |
| | included a medic | cal plan of care for the | | | | | |
| | certification peri | od 4/16/14 through | | | | | |
| | 6/16/14 with ord | lers for skilled nursing to | | | | | |
| | provide services | 2 hours 4 times a week | | | | | |
| | · · | n 2 hours a day for 3 days | | | | | |
| | a week for 7 week | eks to assess / evaluate | | | | | |
| | | s, wound care - right inner | | | | | |
| | | with normal saline apply | | | | | |
| | _ | er with mepilex daily, | | | | | |
| | | t inner buttock - cleanse | | | | | |
| | | ne apply black sponge | | | | | |
| | | um at 125 mmHg and | | | | | |
| | | days. The plan of care | | | | | |
| | | nedication order zosyn | | | | | |
| | _ | to be administered every | | | | | |
| | 8 hours for six d | ays. The record included | | | | | |

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| | IT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE : | |
|-----------|---------------------------------------|------------------------------|--------|------------|--|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | G | | 06/13/ | 2014 |
| NAME OF P | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | KOKOM | 1O, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | `` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | r dated 4/16/14 for home | | | | | |
| | | and treat, written by | | | | | |
| | | :30 PM. The record | | | | | |
| | | e a physician was | | | | | |
| | | wound treatment orders | | | | | |
| | and the IV antibi | otic orders as written on | | | | | |
| | the plan of care. | | | | | | |
| | | | | | | | |
| | A. On a | document titled "MCD | | | | | |
| | [Medicaid] Skill | ed Care Plan / Nursing | | | | | |
| | Visit Note" of th | e same date, 4/16/14, | | | | | |
| | stated, "Discharg | ge from acute hosp | | | | | |
| | [hospital] with o | ngoing extensive wound | | | | | |
| | care needs include | ding cont. [continuous] | | | | | |
| | | therapy - both requiring | | | | | |
| | | nentation indicated the | | | | | |
| | | skilled nurse to provide | | | | | |
| | _ | 4 times a week for 2 | | | | | |
| | | ours a day - 3 days a week | | | | | |
| | | and care per wound | | | | | |
| | · · | nanged every 3 days; a | | | | | |
| | • | a basic metabolic profile | | | | | |
| | _ | /14, and 4/23/14; and to | | | | | |
| | · · · · · · · · · · · · · · · · · · · | er protocol with sterile | | | | | |
| | • | every 7 days. The | | | | | |
| | | , , | | | | | |
| | | evidence a physician was | | | | | |
| | | ders received for the plan | | | | | |
| | _ | RN which included | | | | | |
| | | for the IV antibiotics, | | | | | |
| | | rs, and orders for follow | | | | | |
| | _ | ow hemoglobin and | | | | | |
| | potassium as not | ed on the comprehensive | | | | | |
| | assessment. | | | | | | |
| | | | | | | | |

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| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | SURVEY |
|------------------------------------|----------------------|--------------------------------|--------|------------|--|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BIII | LDING | 00 | COMPLI | ETED |
| | | 157631 | B. WIN | | | 06/13/2 | 2014 |
| C. C | | <u> </u> | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIER | t . | | 1815 S | PLATE STREET | | |
| | RT HOME HEALTH | LLC | | KOKOM | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DLI ICILIACI) | | DATE |
| | | led nurse visit notes dated | | | | | |
| | 5/1/14 and 5/3/1 | • • | | | | | |
| | | cated a dressing change | | | | | |
| | | the left was completed | | | | | |
| | _ | was placed in the wound | | | | | |
| | | k foam as written on the | | | | | |
| | | e record failed to | | | | | |
| | evidence a chang | ge to the plan of care. | | | | | |
| | C 01:11 | lad manna a taka mayar dayar d | | | | | |
| | | led nurse visit note dated | | | | | |
| | _ | d by employee C stated, | | | | | |
| | | I from overnight stay at | | | | | |
| | _ | o have abscess I & D | | | | | |
| | _ | inage]. New wound and | | | | | |
| | IV antibiotics." | | | | | | |
| | evidenced the w | ound on the left buttock | | | | | |
| | was 14.0 cm leng | gth X 3.5 cm width X 0.3 | | | | | |
| | cm depth and the | e wound on the right was | | | | | |
| | 3.0 cm width X | 1.5 cm length X 1.75 cm | | | | | |
| | depth. The recor | rd included a Physician | | | | | |
| | Order from Wals | greens Infusion that listed | | | | | |
| | the medication " | Invanz 1 gram / 100 mL | | | | | |
| | | ne] Mini Bag Plus" and | | | | | |
| | _ | 'Activate bag as directed | | | | | |
| | | se to dissolve completely, | | | | | |
| | _ | nz 1 GM / 100 mL over 1 | | | | | |
| | | nr) once every 24 hours | | | | | |
| | | a gravity set X 7 days." | | | | | |
| | _ | d to evidence physician | | | | | |
| | | w wound beds and that | | | | | |
| | | ysician was consulted | | | | | |
| | | w IV antibiotic orders | | | | | |
| | and wound care. | | | | | | |
| | and wound care. | | | | | | |
| | | | | | | | |

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Event ID:

XOE711 Facility ID: 012349

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| | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY |
|---------------|----------------------|--|--------|---------------|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLETED |
| | | 157631 | B. WIN | | | 06/13/2014 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| COMEO | | 11.0 | | | PLATE STREET | |
| | RT HOME HEALTH | LLC | | KOKOW | 1O, IN 46902 | <u> </u> |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| PREFIX TAG | ` | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETION DATE |
| IAG | | led nurse visit note dated | + | IAG | , | DAIL |
| | | the wound of the left | | | | |
| | | nsed and green foam was | | | | |
| | | ound bed and vacuum | | | | |
| | | the wound on the right | | | | |
| | | nsed with normal saline | | | | |
| | | dressing was applied. | | | | |
| | 1 | to evidence a physician | | | | |
| | | and care provided. | | | | |
| | | and out provided. | | | | |
| | E. Skill | ed nurse visit note dated | | | | |
| | | d the wound of the left | | | | |
| | buttock was clea | nsed and green foam was | | | | |
| | | ound bed and vacuum | | | | |
| | | the wound on the right | | | | |
| | buttock was clea | nsed with normal saline | | | | |
| | and a wet to dry | dressing was applied. | | | | |
| | The record failed | to evidence a physician | | | | |
| | order for the wor | und care provided. | | | | |
| | | | | | | |
| | F. Duri | ng a face to face interview | | | | |
| | on 6/13/14 at 10 | :00 AM, employee M, | | | | |
| | indicated he / she | e completed | | | | |
| | | ssessments and admitted | | | | |
| | - | e health services. He / | | | | |
| | | e office staff obtain the | | | | |
| | | arse in the field does not | | | | |
| | | n orders to treat the | | | | |
| | | ere was a concern or | | | | |
| | _ | e indicated when the | | | | |
| | | he name of the attending | | | | |
| | | assessment document it | | | | |
| | | to the initial order to | | | | |
| | evaluate the pati | ent for home health | | | | |

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PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | | (X2) MULTIPLE CC A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 06/13/2014 | |
|--|--|--|--|--|---|--|
| | ROVIDER OR SUPPLIER | | STREET A 1815 S | ADDRESS, CITY, STATE, ZIP CODE PLATE STREET MO, IN 46902 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | |
| | disciple contacte | ot indicating that the d the physician for and for input in the the plan of care. | | | | |
| | on 6/13/14 at 12: indicated the init evaluate for hom completed by off employee F. What the physician for employee N indinot call the physician for assessment. He of care is written physician and if | ng a telephone interview 19 PM, employee N ial physician order to be health services was fice nurse and named hen asked if he / she calls initial treatment orders, cated that he / she does ician for treatment orders the comprehensive / she indicated the plan and sent to the the physician wishes to s then they may at that | | | | |
| G000175 | The registered nur preventative and r procedures. Based on clinica | REGISTERED NURSE rese initiates appropriate ehabilitative nursing I record and policy view, the agency failed to | G000175 | G175/N543-100% of all active patients were reviewed by the QI | 07/13/2014 | |
| | | ered nurse accurately | | manager. A process was developed and each active chart was reviewed | | |

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| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE | | | |
|-----------|--|------------------------------|--------|---|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DIII | DING | 00 | COMPL | ETED |
| | | 157631 | | LDING | | 06/13/ | 2014 |
| | | | B. WIN | | ADDRESS CITY STATE ZID CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | 8 | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COMEO | | 11.0 | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | KUKUN | MO, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | initiated the "Do | Not Resuscitate" status | | | to ensure the DNR status was | | |
| | of the 1 of 6 hon | ne visit patients (10) with | | | correct. An active patient list was | | |
| | the potential for | patient harm for this | | | compiled to track the audit and | | |
| | | bility to affect all the | | | ensure correct code status. Any | | |
| | patients with adv | | | | chart found that did not have | | |
| | patients with act | vance an ectives. | | | correct DNR/Code status was | | |
| | Eindinge: | | | | corrected by writing an MD order of clarification. A list was compiled to | l | |
| | Findings: | | | | track the audit and ensure correct | | |
| | | | | | code status. This has been | | |
| | Clinical recor | | | | completed as of July 7, 14. The DON | | |
| | physician orders | for the certification | | | and ADON will be responsible for | | |
| | period 3/17/14 tl | hrough 5/15/14. The | | | orientation and education of staff. | | |
| | physician orders | did not evidence a "Do | | | 20% of charts will be audited by the | | |
| | Not Resuscitate" | order. The principal | | | QI manager for the next two month | S | |
| | diagnosis listed | • • | | | to ensure orders are present to | | |
| | Gastrostomy. | was rittention to | | | meet regulations for the medical | | |
| | Gastrostoniy. | | | | plan of care and then quarterly. The | ! | |
| | 2 4 2010 0 | 4 Saniha Madical DOC | | | DON, ADON, or QI manager will be | | |
| | | t Scribe Medical POC | | | responsible to ensure this deficience | У | |
| | l ` ′ | 85 Worksheet CM-3 | | | and the corrective actions are | | |
| | dated 5/13/14 co | ompleted by registered | | | completed by July 13, 14. | | |
| | nurse (RN), Emp | ployee G, indicated both | | | | | |
| | the Full code and | d Do not resuscitate had | | | | | |
| | been marked. A | t a later date the Do not | | | | | |
| | resuscitate had b | een errored out by | | | | | |
| | | date was not present on | | | | | |
| | the error out. | r | | | | | |
| | the circi out. | | | | | | |
| | 2 The physician | a arders for the | | | | | |
| | 3. The physician | | | | | | |
| | | od 5/16/14 through | | | | | |
| | | CODE STATUS: Do not | | | | | |
| | | e principal diagnosis is | | | | | |
| | Dysphagia and c | orophargnyeal. | | | | | |
| | | | | | | | |
| | 4. The Home Ho | ealth Aide Assignment | | | | | |
| | | 7/14 and 5/13/14 does not | | | | | |

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| | OF OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | |
|---------------|----------------------|------------------------------|--------|------------|---|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| NAME OF P | PROVIDER OR SUPPLIER | t | | | DDRESS, CITY, STATE, ZIP CODE | | |
| COMEO | | 11.0 | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | KUKUW | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCE | | DATE |
| | • | nark a whether the | | | | | |
| | - | esuscitated, leaving the | | | | | |
| | aide to make the | ir own decision. | | | | | |
| | 5 0 5/10/14 | . 5.20 D. 6. d. 1: 1 | | | | | |
| | | at 5:30 PM, the licensed | | | | | |
| | | (ST), Employee I, | | | | | |
| | • | tient and re-certified the | | | | | |
| | • | 'Patient demonstrates | | | | | |
| | | ngeal dysphasia resulting | | | | | |
| | in NPO (nothing | by mouth) status. " | | | | | |
| | 6 0 6/10/14 | | | | | | |
| | | t 11:10 AM, Alternate | | | | | |
| | | ing, Employee F, | | | | | |
| | | ng error had been made | | | | | |
| | • | t Resuscitate on the | | | | | |
| | | e. The software company | | | | | |
| | | Not Resuscitate coding. | | | | | |
| | | gned the POC/485 as a | | | | | |
| | | ate. The patient is really | | | | | |
| | | f have been going to the | | | | | |
| | | /14 till today (6/13/14) | | | | | |
| | * | ssion the patient was a | | | | | |
| | Do Not Resuscit | ate. | | | | | |
| | | | | | | | |
| | | policy titled "Do Not | | | | | |
| | | us" stated, "A written | | | | | |
| | | be issued by the patient's | | | | | |
| | primary physicia | , | | | | | |
| | | g the patient's hospital | | | | | |
| | - | r must be obtained for | | | | | |
| | use by the home | health agency)." | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

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Facility ID: 012349

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 157631 06/13/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1815 S PLATE STREET COMFORT HOME HEALTH LLC **KOKOMO. IN 46902** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG G000224 484.36(c)(1) **ASSIGNMENT & DUTIES OF HOME HEALTH AIDE** Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. G000224 G224-Staff will be educated on 07/13/2014 updating the home health aide Based on clinical record review and written instructions/careplan with interview, the agency failed to ensure the change of condition, safety home health aide written care instructions precautions and specific duties. were updated in relation to the patient 100% of charts will be audited by having been assessed and found to have DON/ADON/QI manager by July 11, skin breakdown in 2 of 7 records 14 to ensure that the HHA careplan is updated at least every 60 days. reviewed of patients that received home Quarterly QI review will continue to health services (# 3 and 6) creating the audit HHA careplans for compliance. potential to affect all of the agency's The DON and ADON will be current patients receiving home health responsible for orientation and aide services. education of staff. 20% of charts will be audited by the QI manager for the next two months to ensure Findings include: orders are present to meet regulations for the medical plan of 1. Clinical record number 3 included a care and then quarterly. The DON, plan of care dated 5/20/14 to 7/18/14 for ADON, or QI manager will be home health aide services 6 - 10 hours a responsible to ensure this deficiency day for 3 - 6 days a week throughout the and the corrective actions are completed by July 13, 14. certification period. The plan of care failed to evidence specific duties to be performed by the home health aide.

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MUL | TIPLE CO | NSTRUCTION 00 | (X3) DATE SURVEY COMPLETED | | |
|--|---------------------|---|----------|---------------|--|----------|--------------------|
| | | 157631 | A. BUILD | ING | | 06/13/ | |
| | | | B. WING | STREET A | DDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| NAME OF F | PROVIDER OR SUPPLIE | R | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | ILLC | 1 | KOKOM | IO, IN 46902 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | | REFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE. | COMPLETION DATE |
| TAG | | included a home health | | IAU | | | DATE |
| | | sheet signed and dated | | | | | |
| | _ | ed Nurse on 1/16/14, | | | | | |
| | | 5/14 that failed to | | | | | |
| | · · | | | | | | |
| | | ed instructions to the aide | | | | | |
| | _ | er skin breakdown of the | | | | | |
| | neers and other | bony prominences. | | | | | |
| | 2. Clinical reco | ord 6 evidenced a | | | | | |
| | prescription, wr | itten by an orthopedic | | | | | |
| | physician dated | 5/13/14. The | | | | | |
| | prescription ord | ered Lovenox [short term | | | | | |
| | use anticoagular | nt to prevent clotting] 40 | | | | | |
| | milligrams subc | utaneous for 10 days, | | | | | |
| | "post op [after s | urgery] P.T.[physical | | | | | |
| | therapy]: Strict | TTWB [toe touch weight | | | | | |
| | bearing] left low | ver extremity, hip | | | | | |
| | precautions, if n | ot complainant with | | | | | |
| | weight bearing i | restriction, bed to chair | | | | | |
| | transfers only, d | aily dressing changes, left | | | | | |
| | hip with foam ta | ape." | | | | | |
| | | | | | | | |
| | | cord failed to evidence the | | | | | |
| | | e was instructed on safety | | | | | |
| | | ake while assisting the | | | | | |
| | _ | le assignment sheet dated | | | | | |
| | | ed the patient was post left | | | | | |
| | | / revision and stated, | | | | | |
| | | nt] to become more | | | | | |
| | independent." | | | | | | |
| l | 3. On June 12. | 2014, at 5:10 PM, | | | | | |
| | | icated the information | | | | | |
| | | ssignment sheet and the | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XOE711 Facility ID: 012349

If continuation sheet Page 58 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE | | | SURVEY | | |
|--|---|---|--|--------|--|-------------------------------------|------------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING COMPL | | ETED | | |
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1815 S PLATE STREET KOKOMO, IN 46902 | | | | |
| (X4) ID | SUMMARY S | FATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION | ΓΕ | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | information on the pre-admit and no | ne prescription was of acted upon. | | | | | |
| G000229 | this section) must the patient's home every 2 weeks. Based on clinical review and intervensure the registe supervisory visit every 14 days in of patients who re | ribed in paragraph (d)(1) of make an on-site visit to eno less frequently than a large record and policy view, the agency failed to ered nurse completed a of the home health aide a large received skilled and e services longer than 14 | G00 | 0229 | DON and ADON will educate nursing and therapy staff on timeliness of supervisory visits. The QI manager will audit 20% new and current charts monthl for the next year to ensure supervisory visits are done by RN or therpist in accordance with the regulation. DON, ADON ar QI manager are responsible. The deficiency will be corrected by July 13, 14. | of y the vith ad The | 07/13/2014 |
| | "Home Health A number 2.49 stat client is receiving home health care make a supervisor client's residence 2. Clinical record | agency policy titled ide Supervisory Visits" ed, "When a patient / g skilled services, a e RN or therapist will ory visit to the patient's / e at least every 14 days." d 6 included a verbal employee N dated | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XOE711

Facility ID: 012349

If continuation sheet Page 59 of 111

PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | |
|-----------|---|-------------------------------|--------|------------|-------------------------------------|-------------------------|----------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: 157631 | A. BUI | LDING | 00 | COMPLETED 06/13/2014 | |
| | | 107001 | B. WIN | | | 00/13/2014 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COMFOR | RT HOME HEALTH | LLC | | | PLATE STREET 10, IN 46902 | | |
| (X4) ID | | FATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIATE | | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE | \dashv |
| | · · · · · · · · · · · · · · · · · · · | Home Health Care | | | | | |
| | - | nurse Q O W [every | | | | | |
| | - | A 1-3 h 3 d w 1 [home | | | | | |
| | | o three hours a day three | | | | | |
| | • | one week.] PT Eval | | | | | |
| | | evaluation] and Treat." | | | | | |
| | | e visit notes evidenced | | | | | |
| | aides services we | | | | | | |
| | 1 3 ., | A, 4 hours a day from | | | | | |
| | May 15 through 31, 2014. The record | | | | | | |
| | evidenced the physical therapist | | | | | | |
| | completed the ev | valuation on 5/23/14 and | | | | | |
| | treatments were | provided on May 23, 27, | | | | | |
| | and 29 and June | 3 and 5, 2014. | | | | | |
| | | | | | | | |
| | | record failed to evidence | | | | | |
| | | apist or a skilled nurse | | | | | |
| | • | ervisory visit at least | | | | | |
| | every 14 days. | | | | | | |
| | 3. On June 12, 2 | 2014, at 5:10 PM, | | | | | |
| | - | cated there was no | | | | | |
| | | on to evidence for this | | | | | |
| | record. | | | | | | |
| | | | | | | | |
| G000337 | 484.55(c) | | | | | | |
| 200001 | DRUG REGIMEN | REVIEW | | | | | |
| | | ve assessment must | | | | | |
| | | f all medications the | | | | | |
| | | using in order to identify | | | | | |
| | | rse effects and drug | | | | | |
| | reactions, including ineffective drug therapy, significant side effects, significant drug | | | | | | |
| | | cate drug therapy, and | | | | | |
| | noncompliance wit | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XOE711

Facility ID: 012349

If continuation sheet

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| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C | CONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED |
|---------------|--|---|-----------------|--|-------------------------------|
| 12.12.12.11 | | 157631 | A. BUILDING | | 06/13/2014 |
| | | | B. WING STREET | ADDRESS, CITY, STATE, ZIP CODE | 1 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S PLATE STREET | |
| COMFOR | RT HOME HEALTH | LLC | коко | MO, IN 46902 | |
| (X4) ID | | FATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX TAG | * | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE COMPLETION DATE |
| | | , | G000337 | G337-100% of admission/recert | 07/13/2014 |
| | | l record review, the | | charts are audited by the | :- |
| | agency failed to | assess and identify all | | DON/ADON. The RN case manager reviewing 100% of the pt meds in | IS |
| | the patients medi | ications during the | | the home upon admission, recert | |
| | • | ssessment in 1 of 11 | | and any change that occurs. The | |
| | • | cords reviewed with | | meds are entered into the med | |
| | admission during | g 2014. (6) | | profile and are printed out for the RN case manager to review and sig | n |
| | The findings are: | : | | and placed in the chart. Meds are updated as needed into the system | |
| | Clinical record 6 | | | and placed in the chart upon updating. The DON and ADON will | |
| | prescription, written by an orthopedic | | | be responsible for orientation and | |
| | | ted 5/13/14. The | | education of staff. 20% of charts w | ill |
| | | ered Lovanox [short term | | be audited by the QI manager for the next two months to ensure | |
| | _ | t to prevent clotting] 40 | | orders are present to meet | |
| | _ | itaneous for 10 days. | | regulations for the medical plan of | |
| | - | ive assessment was | | care and then quarterly. The DON, | |
| | • | 15/14 by employee N. failed to include the | | ADON, or QI manager will be responsible to ensure this deficient | CV. |
| | | edication review did not | | and the corrective actions are | - y |
| | include the lover | | | completed by July 13, 14. | |
| | merade the lover | IUA. | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| N000000 | | | | | |
| 14000000 | | | | | |
| | This was a state survey. | home health relicensure | N000000 | | |
| | Survey dates: Ju | nne 11, 12 and 13, 2014 | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 61 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE | | | SURVEY | | |
|--|--|--|---------|---------------|--|--------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 00 | COMPL | ETED |
| | | 157631 | B. WING | | | 06/13/ | 2014 |
| NAME OF B | DOVIDED OD GUDDI IED | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | 1815 S | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | KOKON | 1O, IN 46902 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | ID | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX TAG | ` | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | COMPLETION DATE |
| TAG | | | | TAG | | | DATE |
| | Facility #:: 0123 | 149 | | | | | |
| | Medicaid #: 201004280 Surveyors: Bridget Boston, RN, PHNS Lead Surveyor | | | | | | |
| | | | | | | | |
| | • | an E. Sparks, RN, PHNS | | | | | |
| | Quality Review: BSN, RN | Joyce Elder, MSN, | | | | | |
| | June 20, 2014 | | | | | | |
| N000522 | a written medical p | Medical care shall follow blan of care established viewed by the physician, or, optometrist or | | | | | |
| | Based on interview and review of clinical records and policy, the agency failed to ensure the medical care provided to the patient followed the medical plan of care as established by the physician and the attending physician was consulted and orders were obtained, prior to the provision of skilled care, and documented for all skilled care, services, and treatments to be provided in 7 of 12 clinical records reviewed (1, 2, 5, 9, 10, 11, and 12) with the potential to effect all current 150 patients. Findings: 1. On 6/11/14 at 1:20 PM, a co-owner, | | N00 | 0522 | G158/N522- The agency will ensure that all active patient charts will be reviewed by DON, ADON or QI Manager for MD notification of POC by SN and/or therapists. If the review shows the MD was not contacted by being documented on page 1 of the disciplines careplan, then the MD will be contacted by phone by 7-11-14 and a clarification order will be written that the MD was contacted regarding the development of the POC. This will be monitored ongoing on every new admit and recert by the DON and/or ADON with review of paperwork as it is turned in. The DON and ADON will be responsible for orientation and education of staff. 20% of charts | e | 07/13/2014 |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 62 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE S | SURVEY | |
|--|---|------------------------------|------------|-------------|---|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BIII | LDING | 00 | COMPLI | ETED |
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| | | <u> </u> | | | ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | PLATE STREET | | |
| COMFO | RT HOME HEALTH | LLC | | | 10, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | `` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | COMPLETION |
| TAG | <u> </u> | LSC IDENTIFYING INFORMATION) | | TAG | · | | DATE |
| | | licated the agency used at | | | will be audited by the QI manager | | |
| | least two software programs for the | | | | for the next two months to ensure | | |
| | electronic health | records, one specifically | | | orders are present to meet regulations for the medical plan of | | |
| | for medicare pat | ients, and one | | | care and then quarterly. The DON, | | |
| | specifically for r | nedicaid patients, and | | | ADON, or QI manager will be | | |
| | indicated the surveyors would not be | | | | responsible to ensure this deficiency | y | |
| | granted a read or | nly access to the | | | and the corrective actions are | | |
| | electronic clinical records; access would be through the staff. 2. Clinical record 12, start of care | | | | completed by July 13, 14. | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | 5/19/14, failed to evidence a plan of care | | | | | | |
| | signed by the physician at the time of the | | | | | | |
| | | 4. A verbal order was | | | | | |
| | · · | | | | | | |
| | obtained 5/19/14 | | | | | | |
| | | reat skilled nurse 2 times | | | | | |
| | | week, physical therapy | | | | | |
| | | reat and occupational | | | | | |
| | ~ - | on and treat. The | | | | | |
| | | I the verbal order | | | | | |
| | 5/27/14. | | | | | | |
| | | | | | | | |
| | A. The phy | sical therapy evaluation | | | | | |
| | was performed 5 | 5/24/14 with requested | | | | | |
| | visits 1 times we | eek times 1 week, 2 times | | | | | |
| | week times 4 we | eeks, then 1 time for 1 | | | | | |
| | | ical therapy form did not | | | | | |
| | | sician had been notified | | | | | |
| | ^ * | n had not signed the | | | | | |
| | physical therapy | _ | | | | | |
| | physical dictapy | order for visits. | | | | | |
| | B. The occu | upation therapy evaluation | | | | | |
| | was performed 5 | 5/20/14 with requested | | | | | |
| | visits 2 times we | eek times 2 weeks and 1 | | | | | |

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PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY | |
|--|---|---|----------------------------------|---------------|---|--------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING COMPLETED | | | | ETED |
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| NAME OF I | PROVIDER OR SUPPLIER |) | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | 1815 S | PLATE STREET | | |
| COMFOR | COMFORT HOME HEALTH LLC | | | KOKOM | 1O, IN 46902 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) | |
| PREFIX TAG | ` | ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| TAG | | nes 3 weeks. The | | IAG | , | | DATE |
| | | rapy form did not | | | | | |
| | _ | sician had been notified | | | | | |
| | | n had not signed the | | | | | |
| | | rapy order for visits. | | | | | |
| | | rapy order for visits. | | | | | |
| | C. The clinical record evidenced skilled nurse visits without orders week 3 | | | | | | |
| | | | | | | | |
| | on 5/29/14 and week 4 on 6/2/14; | | | | | | |
| | physical therapy visits without orders | | | | | | |
| | week 3 on 5/28/14 and 5/30/14 and week | | | | | | |
| | 4 on 6/3/14 and 6/5/14; and occupational | | | | | | |
| | | thout orders week 3 on | | | | | |
| | | 9/14 and week 4 on | | | | | |
| | 6/3/14. | | | | | | |
| | | | | | | | |
| | 3. The undated | policy titled "Physician's | | | | | |
| | Plan Of Treatme | ent" number 2.18, stated, | | | | | |
| | "A physician au | thorizes a plan of | | | | | |
| | treatment prepar | red by the agency. | | | | | |
| | Admission order | rs will be obtained prior | | | | | |
| | to evaluation and | d treatment of the patient. | | | | | |
| | Verbal order | rs may be accepted by | | | | | |
| | professional nur | sing staff from a | | | | | |
| | physician or staf | ff nurse. They must be | | | | | |
| | signed and dated | d within thirty (30) days. | | | | | |
| | Verbal orders ar | e to be recorded in the | | | | | |
| | patient's clinical | record by the | | | | | |
| | professional rece | eiving them A | | | | | |
| | _ | of care must include: | | | | | |
| | | equency of services | | | | | |
| | | ions, specific orders for | | | | | |
| | | its Any changes to | | | | | |
| | | | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 64 of 111

PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | |
|--|---|------------------------------|---|------------|-------------------------------|------------|-------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | G | | 06/13 | /2014 |
| NAME OF I | PROVIDER OR SUPPLIER | t | | | DDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | PLATE STREET | | |
| COMFO | RT HOME HEALTH | LLC | | KOKON | 1O, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | | ATE | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | lan of treatment shall be | | | | | |
| | reviewed by the | attending physician." | | | | | |
| | | | | | | | |
| | | policy titled "Medication | | | | | |
| | Administration (| Guidelines" number 2.57 | | | | | |
| | stated, "Antibiot | ics a. Nurses are only | | | | | |
| | permitted to give | e the initial dose in the | | | | | |
| | home with know | ledge of the physician | | | | | |
| | and specific orde | ers for treatment of a | | | | | |
| | reaction are provided by the physician | | | | | | |
| | The nurse should observe the patient / | | | | | | |
| | client for any reaction for at least 30 | | | | | | |
| | 1 | e dose is given | | | | | |
| | | cation administration by | | | | | |
| | | patient / client's clinical | | | | | |
| | _ | e: a. medication name, | | | | | |
| | · · | . medication date and | | | | | |
| | | re the patient / client for | | | | | |
| | | ts and document, 1. | | | | | |
| | | cian order for medication | | | | | |
| | | | | | | | |
| | | 2. Verify the date and | | | | | |
| | | nedication administration | | | | | |
| | | documentation in the | | | | | |
| | patient / client re | ecord." | | | | | |
| | | | | | | | |
| | | rd 1, start of care (SOC) | | | | | |
| | evidenced a plan | | | | | | |
| | • | od 5/23/14 through | | | | | |
| | 6/11/14 with ord | lers for skilled nurse once | | | | | |
| | a week for eight | weeks, physical therapy | | | | | |
| | to evaluate and t | reat, and occupational | | | | | |
| | therapy to evalua | ate and treat by the | | | | | |
| | ~ - | mployee B signed the | | | | | |
| | | dated 5/21/14 indicating | | | | | |
| | I * | \mathcal{L} | 1 | | | | I |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 65 of 111

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | A. BUILDING B. WING | | | COMPLETED 06/13/2014 | | |
|---|--|---|--------|---------------|---|--------|--------------------|
| | | 157501 | B. WIN | | DDDEGG GITW GTATE ZID GODE | 00/10/ | |
| NAME OF I | PROVIDER OR SUPPLIEF | R | | | ADDRESS, CITY, STATE, ZIP CODE PLATE STREET | | |
| COMFO | RT HOME HEALTH | LLC | | | 10, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | COMPLETION DATE |
| 1710 | | as received for these | | mo | · | | DATE |
| | | 4. The record failed to | | | | | |
| | | bal order referenced. | | | | | |
| | C vidence the ver | our order referenced. | | | | | |
| | A. The | record included a two | | | | | |
| | page referral dat | ed 5/21/14 which was | | | | | |
| | | yee B. The referral did | | | | | |
| | not include a ver | bal order as written on | | | | | |
| | the plan of care. | | | | | | |
| | | | | | | | |
| | B. A physician order dated 5/23/14, written by employee K, indicated a verbal order was obtained | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | from the attending | ng physician for home | | | | | |
| | health care evalu | ate and treat, skilled | | | | | |
| | nurse one visit d | uring week one, and | | | | | |
| | physical therapy | and occupational | | | | | |
| | therapy to evalua | ate and treat the week of | | | | | |
| | May 25, 2014. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | _ | - | | | | | |
| | | * | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | - | | | | | |
| | visits and the sei | vices provided. | | | | | |
| | 6 Clinical reco | rd # 2 SOC 2/21/14 | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | 1 | | | | | | |
| | from the attendine health care evaluation nurse one visit dephysical therapy therapy to evaluate May 25, 2014. C. The occupational the assessment on 5, additional visits 2014. The recomplysicians order visits and the serior of the control of the recertification of the recent of the r | ng physician for home nate and treat, skilled uring week one, and and occupational ate and treat the week of record evidenced the rapist completed an /31/14 and completed on June 2 and June 4, d failed to evidence a for the occupational | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 66 of 111

PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | INSTRUCTION | (X3) DATE | | |
|---|---|------------------------------|------------|--|--------------------------------|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | IG | | 06/13/ | /2014 |
| NAME OF I | PROVIDER OR SUPPLIER | 1 | | 1 | ADDRESS, CITY, STATE, ZIP CODE | | |
| OOMEO | ST LIGNE LIENT TH | | | | PLATE STREET | | |
| COMFOR | MFORT HOME HEALTH LLC | | | KUKUN | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · · | CY MUST BE PRECEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPR | | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | * | week for nine weeks, | | | | | |
| | • | l and physical therapy | | | | | |
| | were to evaluate | and treat. | | | | | |
| | | | | | | | |
| | | record included a medical | | | | | |
| | • | he certification period | | | | | |
| | 4/22/14 through | 6/20/14 with orders for | | | | | |
| | the skilled nurse | services once a week for | | | | | |
| | nine weeks, aide | services twice a week | | | | | |
| | for nine weeks, physical therapy services | | | | | | |
| | twice a week for four weeks then once a | | | | | | |
| | week for two weeks, and occupational | | | | | | |
| | therapy once a week for two weeks, twice | | | | | | |
| | a week for two v | veeks, and once a week | | | | | |
| | for two weeks. | | | | | | |
| | | | | | | | |
| | B. The | record evidenced the | | | | | |
| | | st reassessed the patient | | | | | |
| | | n days prior to the start | | | | | |
| | | on period. The record | | | | | |
| | | e an assessment by | | | | | |
| | | occurred on or after the | | | | | |
| | | cian order to assess dated | | | | | |
| | | cord failed to evidence | | | | | |
| | | nade during week four of | | | | | |
| | | • | | | | | |
| | · ' | period. The record | | | | | |
| | | sit was made on May 14, | | | | | |
| | 2014. | | | | | | |
| | | 1011. | | | | | |
| | | record failed to evidence | | | | | |
| | _ | services were provided | | | | | |
| | - | of the certification | | | | | |
| | period. | | | | | | |
| | | | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 67 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | SURVEY | |
|--|---|--|------------|--|--------------------------------|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BUI | LDING | 00 | COMPL | ETED |
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| NAME OF A | DOLUBER OR GURRUSES | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| NAME OF I | PROVIDER OR SUPPLIEF | C | | 1815 S | PLATE STREET | | |
| | RT HOME HEALTH | | | l | 1O, IN 46902 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | | PROVIDER'S PLAN OF CORRECTION | | |
| PREFIX | | ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE PROPERTY | | TE | COMPLETION |
| TAG | | · · · · · · · · · · · · · · · · · · · | | TAG | DEFICIENCY) | | DATE |
| | | record failed to evidence | | | | | |
| | the occupation therapy services were | | | | | | |
| | - | ered. There were no | | | | | |
| | occupational visits made during week | | | | | | |
| | one. | | | | | | |
| | | | | | | | |
| | 7. Clinical record 5, start of care 4/16/14, | | | | | | |
| | | cal plan of care for the | | | | | |
| | certification period 4/16/14 through 6/16/14 with orders for skilled nursing to | | | | | | |
| | | | | | | | |
| | provide services 2 hours 4 times a week for 2 weeks, then 2 hours a day - 3 days a | | | | | | |
| | | | | | | | |
| | week for 7 week | s to assess / evaluate all | | | | | |
| | body systems, w | ound care - right inner | | | | | |
| | | with normal saline, | | | | | |
| | · · | nd cover with mepilex | | | | | |
| | | d care - left inner buttock | | | | | |
| | _ | ormal saline, apply black | | | | | |
| | | nd vacuum at 125 | | | | | |
| | | every 3 days. The plan of | | | | | |
| | | IV medication order for | | | | | |
| | | grams to be administered | | | | | |
| | | r six days. The record | | | | | |
| | | cian order dated 4/16/14 | | | | | |
| | | evaluate and treat, | | | | | |
| | | byee K at 4:30 PM. The | | | | | |
| | 1 | evidence a physician was | | | | | |
| | | ound treatment orders and | | | | | |
| | | orders as written on the | | | | | |
| | | orders as written on the | | | | | |
| | plan of care. | | | | | | |
| | | record included a | | | | | |
| | comprehensive a | assessment dated 4/16/14, | | | | | |
| | completed by en | nployee K, that indicated | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 68 of 111

PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|------------------------------------|---|------------------------------|----------------------------|--------|---|--------|------------|
| ANDILAN | OF CORRECTION | 157631 | A. BUI | LDING | 00 | 06/13/ | |
| | | 137031 | B. WIN | | | 00/13/ | 2014 |
| NAME OF I | PROVIDER OR SUPPLIER | t | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COMFOR | RT HOME HEALTH | LLC | | | PLATE STREET 10, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | d between 7:15 PM and | | | | | |
| 9:15 PM, included the diagnoses of | | | | | | | |
| | | itis and acute renal | | | | | |
| | _ | ent had been discharged | | | | | |
| | | l the same day, 4/16/14, | | | | | |
| | assessed to have | a peripherally inserted | | | | | |
| | central catheter | [PICC] line inserted on | | | | | |
| | 4/9/14 at the left | antecubital space, no | | | | | |
| | arm circumferen | ce or the length of the | | | | | |
| | tubing exposed was documented, and | | | | | | |
| | lack of knowledge related to medication | | | | | | |
| | administration w | as identified and | | | | | |
| | documented. Po | st operative surgical | | | | | |
| | debridement of v | wounds during the | | | | | |
| | hospitalization - | wound description on | | | | | |
| | the left inner but | tock / perineum was 16.5 | | | | | |
| | centimeters (cm) |) width X 3.3 cm length | | | | | |
| | X 1.8 cm depth, | 20 percent eschar and 80 | | | | | |
| | % granulating tis | ssue and the wound on | | | | | |
| | the right inner b | uttock was 2.4 cm width | | | | | |
| | 0.6 cm length X | 0.4 cm depth 15 % | | | | | |
| | _ | and 85 % granulating | | | | | |
| | | ntation for recent | | | | | |
| | abnormal labora | tory results was a hand | | | | | |
| | written arrow do | wnward and "Hgb | | | | | |
| | [hemoglobin]" a | nd "K [potassium]" not | | | | | |
| | value assigned w | vithin the assessment nor | | | | | |
| | where the inforn | nation was obtained. The | | | | | |
| | comprehensive a | assessment and the | | | | | |
| | - | niled to evidence patient / | | | | | |
| | | ion, measurement of | | | | | |
| | _ | ation of the caregiver / | | | | | |
| | patient technique | | | | | | |
| | 1 ^ | measure education | | | | | |
| | | | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 69 of 111

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | 00 | COMP | (X3) DATE SURVEY COMPLETED 06/13/2014 | |
|--|------------------------|---|--|---------------------------------------|--|
| | STREET A 1815 S | PLATE STREET | DE | | |
| CIENCY MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOU | ILD BE | (X5) COMPLETION DATE | |
| ed to medication In via PICC and wound care It er education required with a It ion as to what tasks the It ion as capable of Ind which tasks the nurse It ion a document titled "MCD It is ideal to the same date, 4/16/14, It is in a capable of the same d | TAG | DEFICIENCY) | | DATE | |
| che skilled nurse to provide urs 4 times a week for 2 chours a day - 3 days a week wound care per wound changed every 3 days, a aw - a basic metabolic 8/14, 4/21/14, and 4/23/14, an PICC per protocol, sterile age every 7 days. The to evidence a physician was di orders received for the plan the RN, prior to on. The record failed to aysician order for the IV ose, frequency, begin date, would administer the wound care orders, and | | | | | |
| FORESTA CENTRAL CONTRACTOR OF THE CONTRACTOR OF | IDENTIFICATION NUMBER: | IDENTIFICATION NUMBER: 157631 PLIER THER THE LC THE LC RY STATEMENT OF DEFICIENCIES CHENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION) Ed to medication on via PICC and wound care her education required with a tion as to what tasks the giver was capable of hind which tasks the nurse hete. On a document titled "MCD skilled Care Plan / Nursing of the same date, 4/16/14, harge from acute hosp th ongoing extensive wound heluding cont. [continuous] hous] therapy - both requiring house there wound here were a day - 3 days a week wound care per wound here changed every 3 days, a haw - a basic metabolic 18/14, 4/21/14, and 4/23/14, hain PICC per protocol, sterile hinge every 7 days. The to evidence a physician was dorders received for the plan here RN, prior to hysician order for the IV ose, frequency, begin date, would administer the wound care orders, and | DENTIFICATION NUMBER: 157631 A BUILDING 3 WING STREET ADDRESS, CITY, STATE, ZIP COL 1815 S PLATE STREET KOKOMO, IN 46902 BY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION) and to medication on via PICC and wound care her education required with a tion as to what tasks the giver was capable of and which tasks the nurse lete. Do a document titled "MCD skilled Care Plan / Nursing of the same date, 4/16/14, harge from acute hosp th ongoing extensive wound cluding cont. [continuous] bus] therapy - both requiring cumentation indicated the the skilled nurse to provide hurs 4 times a week for 2 2 hours a day - 3 days a week wound care per wound e changed every 3 days, a haw - a basic metabolic 18174, 4/21/14, and 4/23/14, ain PICC per protocol, sterile hape every 7 days. The to evidence a physician was d orders received for the plan the RN, prior to interpretation indicate, would administer the wound care orders, and | DENTIFICATION NUMBER: 157631 | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 70 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | A. BUI | LDING | NSTRUCTION 00 | (X3) DATE COMPL 06/13 / | ETED | |
|--|------------------------------------|------------------------------|--------|----------------|---|--------|------------|
| | | | B. WIN | | DDDESS CITY STATE ZID CODE | 00.10. | |
| NAME OF I | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE PLATE STREET | | |
| COMFO | RT HOME HEALTH | LLC | | | 10, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | 1 | ID | · | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | IIE. | DATE |
| | hemoglobin and | potassium as noted on | | | | | |
| | the comprehensi | ve assessment. | | | | | |
| | | | | | | | |
| | C. Skill | ed nurse visit note dated | | | | | |
| | 4/17/14 complete | ed by employee P, a | | | | | |
| | licensed practica | l nurse stated, "IV ATB | | | | | |
| | [antibiotic] ran p | er order PICC | | | | | |
| | flushes." Emplo | oyee C completed a | | | | | |
| | skilled nurse visi | it at the same time and | | | | | |
| | documented the Wound Visit Note | | | | | | |
| | Addendum which identified the left | | | | | | |
| | wound was with tunneling or | | | | | | |
| | undermining, wa | s not specific which, 6.0 | | | | | |
| | centimeters at 11 | o'clock, tunneling and | | | | | |
| | / or undermining | which was not | | | | | |
| | documented on t | he comprehensive | | | | | |
| | assessment, and | documentation the left | | | | | |
| | wound was dress | sed with green foam | | | | | |
| | verse the black f | oam as written on the | | | | | |
| | plan of care prior | r to applying the wound | | | | | |
| | vacuum. The vi | sit note and clinical | | | | | |
| | record failed to e | evidence the physician | | | | | |
| | was notified abo | ut the tunneling / | | | | | |
| | undermining and | I the record failed to | | | | | |
| | evidence a physi | cian order for green | | | | | |
| | foam to be used | with the wound vacuum. | | | | | |
| | The visit note an | d clinical record failed to | | | | | |
| | evidence patient | / caregiver education, | | | | | |
| | measurement of | learning, observation of | | | | | |
| | caregiver / patier | nt technique for the PICC | | | | | |
| | care, IV adminis | tration, wound care | | | | | |
| | procedures for le | evel of education, any | | | | | |
| | deficits and educ | eation needs, and a clear | | | | | |
| | delineation whic | h tasks the patient / | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 71 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULT | TPLE CON | NSTRUCTION 00 | (X3) DATE : COMPL | | |
|--|--|---|-----------|------------------------------------|---|--------|--------------------|
| AND TEAN | or condection | 157631 | A. BUILDI | NG | | 06/13/ | |
| | | 107 00 1 | B. WING | | | 00/10/ | 2014 |
| NAME OF I | PROVIDER OR SUPPLIER | 8 | | | DDRESS, CITY, STATE, ZIP CODE PLATE STREET | | |
| COMEO | RT HOME HEALTH | IIC | | | O, IN 46902 | | |
| | | | | | | 1 | (27.5) |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL | | D EFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | ` | LSC IDENTIFYING INFORMATION) | | TAG CROSS-REFERENCED TO THE APPROF | | DATE | |
| | caregiver was co | ompetent to complete. | | | | | |
| | | | | | | | |
| | D. Skil | led nurse visit note dated | | | | | |
| | 4/18/14 complet | ed by employee C, a RN, | | | | | |
| | indicated a blood | d draw was obtained | | | | | |
| | from the PICC a | nd the PICC line was | | | | | |
| | flushed and lock | ed with Heparin. The | | | | | |
| | visit note failed | to evidence who | | | | | |
| | administered the | e IV medications, failed | | | | | |
| | to include a wound assessment, failed to | | | | | | |
| | evidence a body systems assessment, a | | | | | | |
| | line was drawn through 50 % of the visit | | | | | | |
| | note and the syst | tems assessment portion | | | | | |
| | was left blank. | The visit note indicated | | | | | |
| | the skilled nurse | visit lasted only 1/2 | | | | | |
| | hour. The note a | and record failed to | | | | | |
| | explain why the | 2 hour skilled nurse visit | | | | | |
| | was not complet | ed as ordered or an order | | | | | |
| | to reduce the dur | ration of the skilled nurse | | | | | |
| | visits. | | | | | | |
| | | | | | | | |
| | E. Skill | ed nurse visit note dated | | | | | |
| | 4/19/14 complet | ed by employee C stated, | | | | | |
| | "Removed green | foam dressing, cleansed | | | | | |
| | with normal sali | ne, filled with green | | | | | |
| | foam." The doc | umentation failed to | | | | | |
| | evidence an asse | essment of the PICC line, | | | | | |
| | an assessment of | f the right wound, and an | | | | | |
| | assessment of al | l body systems - the | | | | | |
| | portion of the nu | irse visit note was left | | | | | |
| | blank. The visit | note indicated the | | | | | |
| | skilled nurse vis | it lasted only 1 hour. | | | | | |
| | The note and re- | cord failed to explain | | | | | |
| | why the 2 hour s | skilled nurse visit was not | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 72 of 111

PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | | |
|---|----------------------|------------------------------|------------|------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP CODE | | |
| 0014505 | ST LIGNE LIENT TH | | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | KOKOW | IO, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | * | lered and failed to | | | | | |
| | | er to reduce the duration | | | | | |
| | of the skilled nur | rse visits. | | | | | |
| | | | | | | | |
| | | ed nurse visit note dated | | | | | |
| | _ | ed by employee C failed | | | | | |
| | | ssessment of the patient's | | | | | |
| | , , , | e portion of the note was | | | | | |
| | | drawn through, failed to | | | | | |
| | | ssment of the PICC | | | | | |
| | · · | d to assess the wound on | | | | | |
| | | t buttock The note | | | | | |
| | | ssing to the wound on | | | | | |
| | | vas changed and wound | | | | | |
| | | ched. The visit note | | | | | |
| | | e the laboratory draw | | | | | |
| | | written on the plan of | | | | | |
| | care. The visit n | ote indicated the skilled | | | | | |
| | nurse visit lasted | only 3/4 of an hour. | | | | | |
| | The note and red | cord failed to explain | | | | | |
| | why the 2 hour s | killed nurse visit was not | | | | | |
| | completed as ord | lered, and the record | | | | | |
| | | e an order to reduce the | | | | | |
| | duration of the sl | killed nurse visits. | | | | | |
| | | | | | | | |
| | G. Skill | led nurse visit note dated | | | | | |
| | 4/22/14 complete | ed by employee C | | | | | |
| | addressed only the | he wound on the left and | | | | | |
| | indicated the wo | und was tunneling or | | | | | |
| | undermined [not | specified] at 11 o' | | | | | |
| | clock. The docu | mentation evidenced the | | | | | |
| | nurse changed to | wound dressing, applied | | | | | |
| | | e wound bed, and | | | | | |
| | reattached the w | ound vacuum. The visit | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 73 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | | |
|--|--|------------------------------|------------|------------|--|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLETED | |
| | | 157631 | B. WIN | G | | 06/13/2014 | |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| 0014501 | | 11.0 | | | PLATE STREET | | |
| COMFO | RT HOME HEALTH | LLC | | KOKON | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX TAG | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | | |
| TAG | <u> </u> | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE | |
| | | e skilled nurse visit | | | | | |
| | lasted only 1 hour. The note and record failed to explain why the 2 hour skilled | | | | | | |
| | - | | | | | | |
| | | not completed as ordered, | | | | | |
| | | niled to evidence an order | | | | | |
| | | ration of the skilled nurse | | | | | |
| | visits. | | | | | | |
| | П 6121 | led nurse visit note dated | | | | | |
| | | ted by employee P, that | | | | | |
| | | wounds were not | | | | | |
| | | the visit and stated, | | | | | |
| | "Assisted patien | | | | | | |
| | • | | | | | | |
| | | the plan of care indicated | | | | | |
| | | syn was ordered for 6 | | | | | |
| | | 4/16/14. The record | | | | | |
| | _ | why the patient was | | | | | |
| | _ | biotic on the 7th day | | | | | |
| | _ | art of the antibiotic. The | | | | | |
| | | ted the skilled nurse visit | | | | | |
| | 1 | ar and 5 minutes, the note | | | | | |
| | | to explain why the 2 | | | | | |
| | hour skilled nurs | | | | | | |
| | • | dered, and the record | | | | | |
| | | ee an order to reduce the | | | | | |
| | duration of the s | killed nurse visits. | | | | | |
| | T 01.111 | ad manga vijait mata datad | | | | | |
| | | ed nurse visit note dated | | | | | |
| | - | ted by employee P, failed | | | | | |
| | | was provided to the | | | | | |
| | _ | ght and an assessment of | | | | | |
| | | Only the wound on the left | | | | | |
| | | vithin the notes - noted | | | | | |
| | the dressing was | changed. The visit note | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 74 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | INSTRUCTION | (X3) DATE | | |
|--|----------------------|------------------------------|------------|-------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | IG | | 06/13/ | /2014 |
| NAME OF I | PROVIDER OR SUPPLIER | <u> </u> | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| 001450 | | | | | PLATE STREET | | |
| COMFO | RT HOME HEALTH | LLC | | KOKON | 1O, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE. | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | lled nurse visit lasted | | | | | |
| | 1 - | 10 minutes. The record | | | | | |
| | - | why the 2 hour skilled | | | | | |
| | | ot completed as written | | | | | |
| | on the plan of ca | re. | | | | | |
| | | | | | | | |
| | J. Skille | ed nurse visit note dated | | | | | |
| | 4/25/14, complet | ted by employee P, failed | | | | | |
| | to evidence care | was provided to the | | | | | |
| | wound on the rig | ght and an assessment of | | | | | |
| | either wound; or | nly the wound on the left | | | | | |
| | was addressed w | rithin the notes which | | | | | |
| | noted the dressir | ng was changed. The | | | | | |
| | visit note indicat | ted the skilled nurse visit | | | | | |
| | lasted only 1 hou | ar and 40 minutes. The | | | | | |
| | record failed to | explain why the 2 hour | | | | | |
| | | it was not completed as | | | | | |
| | written on the pl | • | | | | | |
| | • | | | | | | |
| | K. Skill | led nurse visit note dated | | | | | |
| | 4/29/14. complet | ted by employee P, | | | | | |
| | _ | ound on the right buttock | | | | | |
| | | the wound on the left was | | | | | |
| | | eters in length X 4.0 cm | | | | | |
| | | was documented and | | | | | |
| | | tunneling [not specified] | | | | | |
| | _ | be 6.0 cm at 11 o'clock, | | | | | |
| | | m sample was collected | | | | | |
| | from the PICC. | - | | | | | |
| | | wound on the left was | | | | | |
| | | en foam and not the black | | | | | |
| | - | | | | | | |
| | | on the plan of care. The | | | | | |
| | | ted the skilled nurse visit | | | | | |
| | lasted only I hou | ar and 10 minutes, the | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 75 of 111

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | (X2) MUL' | | NSTRUCTION 00 | (X3) DATE : COMPL | ETED | |
|--|---|---|---------|--------------------|--|--------|----------------------------|
| | | 157631 | B. WING | | | 06/13/ | 2014 |
| | PROVIDER OR SUPPLIER | | | 1815 S F | DDRESS, CITY, STATE, ZIP CODE PLATE STREET O, IN 46902 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PR | ID REFIX FAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΤE | (X5) COMPLETION DATE |
| | 2 hour skilled nu completed as ord | failed to explain why the urse visit was not dered, and failed to er to reduce the duration rse visits. | | | | | |
| | 5/1/14, complete indicated a dress on the left was c was placed in the | ed nurse visit note dated ed by employee P, sing change to the wound ompleted and green foam e wound bed, not the ritten on the plan of care. | | | | | |
| | 5/3/14, complete indicated a dress on the left was c was placed in the | led nurse visit note dated ed by employee P and sing change to the wound ompleted and green foam e wound bed, not the ritten on the plan of care. | | | | | |
| | 5/7/14, complete "Patient released hospital 5/6/14 to [incision and dra IV antibiotics." evidenced the was 14.0 cm lender cm depth and the 3.0 cm width X depth. The reconstruction of the medication " | led nurse visit note dated and by employee C stated, I from overnight stay at the o have abscess I & D stange]. New wound and Documentation ound on the left buttock gth X 3.5 cm width X 0.3 are wound on the right was 1.5 cm length X 1.75 cm and included a Physician greens Infusion that listed Invanz 1 gram / 100 mL me] Mini Bag Plus" and | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 76 of 111

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SUR COMPLETE | | |
|--|----------------------|---|------------|---------------|--|----------|-------------------|
| ANDILAN | OF CORRECTION | 157631 | | LDING | 00 | 06/13/20 | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | 00/10/20 | |
| NAME OF I | PROVIDER OR SUPPLIEF | t . | | | PLATE STREET | | |
| COMFO | RT HOME HEALTH | LLC | | | 10, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE C | OMPLETION DATE |
| TAG | | were to "Activate bag as | + | TAG | Diricilité 1 y | | DATE |
| | | each dose to dissolve | | | | | |
| | _ | infuse Invanz 1 GM / | | | | | |
| | | our (100 mL / hr) once | | | | | |
| | | per PICC line via gravity | | | | | |
| | | The documentation for the | | | | | |
| | 1 | it failed to evidence a full | | | | | |
| | body systems as | | | | | | |
| | assessment of th | | | | | | |
| | | g the visit. The note | | | | | |
| | - | ed on new antibiotic." | | | | | |
| | | d to evidence orders for | | | | | |
| | the new wound b | peds or that the attending | | | | | |
| | | onsulted regarding the | | | | | |
| | new IV antibioti | c orders and wound care. | | | | | |
| | | | | | | | |
| | O. Skil | led nurse visit note dated | | | | | |
| | 5/8/14 indicated | the wound of the left | | | | | |
| | buttock was clea | insed and green foam was | | | | | |
| | applied to the wo | ound bed and vacuum | | | | | |
| | * * | ound on the right buttock | | | | | |
| | | th normal saline and a | | | | | |
| | 1 | ing was applied. The | | | | | |
| | | evidence a physician | | | | | |
| | order for the wo | und care provided. | | | | | |
| | P. Skill | ed nurse visit note dated | | | | | |
| | 5/10/14 indicate | d the wound of the left | | | | | |
| | | insed and green foam was | | | | | |
| | | ound bed and vacuum | | | | | |
| | | ound on the right buttock | | | | | |
| | | th normal saline and a | | | | | |
| | | ing was applied. The | | | | | |
| | record failed to | evidence a physician | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 77 of 111

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | A. BUILDING B. WING | | | COMPLETED 06/13/2014 | | |
|---|--|--|--------|--------|---|----|------------|
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | ROVIDER OR SUPPLIER | | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | | 10, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | order for the wou | and care provided. | | | | | |
| | Q. The the PICC access during week four period. Skilled completed on Ma The documentating failed to evidence PICC access and record failed to evidence disregard the plant weekly dressing access. 8. Clinical record SOC) 5/15/14, in employee K on the verbal order date employee K recent attending for an explosion of the plant of t | record failed to evidence dressing was changed of the certification nurse visits were ay 7, 8, and 10, 2014. On from these visits an assessment of the a dressing change. The evidence an order to a for care order for changes to the PICC. d #9, start of care (acluded the signature of the referral form, and a and 5/14/14 that evidenced dived an order from the evaluation and treatment therapy and physical record evidenced ducted the | | | | | |
| | • | ssessment on 5/15/14 | | | | | |
| | and employee L | * | | | | | |
| | occupational the | rapy assessment on | | | | | |
| | 5/16/14. The pla | n of care for the | | | | | |
| | certification peri | od 5/15/14 through | | | | | |
| | • | y employee B on 5/12/14 | | | | | |
| | | for physical therapy once | | | | | |
| | | rst week and twice a | | | | | |
| | a week for the fil | ist week and twice a | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 78 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | (X2) MULTIPLI A. BUILDING | E CONSTRUCTION 00 | COM | TE SURVEY MPLETED 13/2014 | |
|--|---|--|---------------------|---|---------------------------------|----------------------------|
| | | 157651 | B. WING | | _ | 13/2014 |
| | PROVIDER OR SUPPLIER | | | EET ADDRESS, CITY, STATE, ZIF 5 S PLATE STREET | P CODE | |
| COMFO | RT HOME HEALTH | LLC | KOK | (OMO, IN 46902 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| 170 | week for the foll occupational the | owing four weeks and rapy twice a week for hen once a week during | TAG | | | DAIL |
| | employee K indi | - | | | | |
| | evidence the atternoon consulted for orchealth agency bar identified in the assessment and to | - | | | | |
| | included the med 3/17/14 through skilled nurse twi and once a week services twice a once a week for physical therapy weeks and once and once during therapy twice a very beginning week | d# 10, SOC 3/17/14, dical plan of care dated 5/15/14 with orders for ce a week for week one for eight weeks, aide week for four weeks and the following five weeks, twice a week for four a week for four weeks week nine, and speech week for eight weeks two of the certification ord evidenced that | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 79 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SUI | RVEY | |
|--|----------------------|------------------------------|------------|---------------|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLETI | |
| | | 157631 | B. WIN | G | | 06/13/20 | 14 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | ROVIDER OR SOLLEE | | | | PLATE STREET | | |
| | RT HOME HEALTH | LLC | | KOKOM | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE C | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | BEI ICIENCT) | | DATE |
| | | of the certification | | | | | |
| | 1 1 | ch therapy visit was | | | | | |
| | - | were made during week | | | | | |
| | three, and one di | uring week seven. | | | | | |
| | 10. Clinical reco | ord # 11, start of care | | | | | |
| | | a medical plan of care | | | | | |
| | · · | ion period 3/3/14 through | | | | | |
| | | ers for skilled nurse visits | | | | | |
| | once a week for | eight weeks and Physical | | | | | |
| | | d Occupational Therapy | | | | | |
| | (OT) to evaluate | | | | | | |
| | | | | | | | |
| | A. The | record evidence the | | | | | |
| | skilled nurse cor | npleted the | | | | | |
| | | assessment on 3/3/14, the | | | | | |
| | - | e their evaluation and | | | | | |
| | _ | 3/5/14, and the OT | | | | | |
| | _ | evaluation and began | | | | | |
| | • | /14. The record failed to | | | | | |
| | | ending physician was | | | | | |
| | | ling the development of | | | | | |
| | _ | of care based on the | | | | | |
| | needs identified | | | | | | |
| | | and therapy assessment | | | | | |
| | and treatment or | | | | | | |
| | | | | | | | |
| | B. The | record evidenced a | | | | | |
| | Physician order | dated 5/1/14 to complete | | | | | |
| | a reassessment f | or the home health | | | | | |
| | needs, skilled nu | irse services once a week | | | | | |
| | for eight weeks l | begriming May 4, 2014. | | | | | |
| | _ | , "Area 5 non-skilled | | | | | |
| | | lth aide]" to begin week | | | | | |

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PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATE SURVEY | | |
|--|---------------------|---|---------------|--|------------------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED | |
| | | 157631 | B. WING | | 06/13/2014 | |
| NAME OF | PROVIDER OR SUPPLIE | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | S PLATE STREET | | |
| | RT HOME HEALTH | | | MO, IN 46902 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | |
| PREFIX TAG | ` | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPRO DEFICIENCY) | PRIATE COMPLETION DATE | |
| 1710 | + | for two hours, five days a | 1710 | | DATE | |
| | | weeks. A re-assessment | | | | |
| | | on 5/1/14 by a registered | | | | |
| | | entified the patient | | | | |
| | | ve a decubitus present and | | | | |
| | a follow up plan | • | | | | |
| | | riod 5/2/14 through | | | | |
| | 1 | veloped with orders for | | | | |
| | | weekly. The plan of care | | | | |
| | | e the aide services. The | | | | |
| | record failed to | evidence the agency | | | | |
| | | the attending physician to | | | | |
| | develop of the r | medical plan of care based | | | | |
| | on he findings of | of the comprehensive | | | | |
| | assessment and | failed to evidence aide | | | | |
| | services were p | rovided as noted on the | | | | |
| | 5/1/14 order. | | | | | |
| | | | | | | |
| | | at 2:08 PM, employee A | | | | |
| | | asked, the referral is | | | | |
| | | he office nurse and that | | | | |
| | - | was to write the name of | | | | |
| | | the assessment which | | | | |
| | _ | ey contacted the attending | | | | |
| | physician for tro | eatment orders. | | | | |
| | 12 0 6/12/14 | 1.15 DM 1 | | | | |
| | | at 1:15 PM, employee O | | | | |
| | | ne only places the name of | | | | |
| | | the form but he does not | | | | |
| | | sician for treatment orders ice staff obtained the | | | | |
| | | | | | | |
| | | s. When asked to clarify, | | | | |
| | | licated he / she was | | | | |
| | leterring to the | initial order obtained for | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 81 of 111

PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | | |
|---|----------------------|------------------------------|------------|------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | | | 06/13/ | /2014 |
| NAME OF I | PROVIDER OR SUPPLIER | 8 | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| 0011505 | ST. I OME I IEM TI | | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | KOKON | 1O, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE. | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | the evaluation of | the patient. | | | | | |
| | | | | | | | |
| | _ | ce to face interview on | | | | | |
| | | AM, employee M, | | | | | |
| | indicated he / sh | e completed | | | | | |
| | comprehensive a | assessments and admitted | | | | | |
| | patients for hom | e health services. He / | | | | | |
| | she indicated the | e office staff obtain the | | | | | |
| | orders and the nu | urse in the field does not | | | | | |
| | call for physician | n orders to treat the | | | | | |
| | patient unless the | ere was a concern or | | | | | |
| | - | ne indicated when the | | | | | |
| | clinician writes t | the name of the attending | | | | | |
| | | assessment document it | | | | | |
| | | to the initial order to | | | | | |
| | | ent for home health | | | | | |
| | _ | ot indicating the disciple | | | | | |
| | | ysician for treatment | | | | | |
| | | put in the development | | | | | |
| | of the plan of car | | | | | | |
| | of the plan of car | ie. | | | | | |
| | 14 D ::: | 1 | | | | | |
| | _ | ephone interview on | | | | | |
| | | PM, employee N | | | | | |
| | | tial physician order to | | | | | |
| | | ne health services was | | | | | |
| | | fice nurse named | | | | | |
| | | nen asked if he / she calls | | | | | |
| | the physician for | r initial treatment orders, | | | | | |
| | | cated he / she does not | | | | | |
| | call the physician | n for treatment orders | | | | | |
| | after completing | the comprehensive | | | | | |
| | assessment. He | / she indicated the plan | | | | | |
| | of care is written | and sent to the | | | | | |
| | physician and if | the physician wishes to | | | | | |
| | | | 1 | | | | I |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 82 of 111

PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | JETIPLE CO. | NSTRUCTION | (X3) DATE | | |
|--|--|--|-------------|------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | G | | 06/13/ | 2014 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | DDRESS, CITY, STATE, ZIP CODE | | |
| COMFOR | RT HOME HEALTH | LLC | | 1 | PLATE STREET IO, IN 46902 | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | | ID | DROVIDEDIC DI AN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | change the order time. | s then they may at that | | | | | |
| | indicated the pronotification was that a visit was m form titled "Cont Visit (s) Medicar was missed and to notified by sendi physician. She in not contacted by the missed visit was the missed visit was more more more missed visit was more more more more more more more more | at 3:32 PM, employee A cess for missed visit when the office staff find missed, they write on a fidential Fax Missed the Patient" that the visit then the physician was not the form to the indicated the physician is the discipline prior to visit. She indicated the the twas to notify the missed visit. | | | | | |
| N000524 | plan of care shall: (A) Be developed home health agent (B) Include all ser skilled service is b (B) Cover all pertition (C) Include the fold (i) Mental status (ii) Types of servequired. | 1) As follows, the medical in consultation with the cy staff. vices to be provided if a eing provided. nent diagnoses. lowing: | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 83 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | (X2) MULTIPLE C | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 06/13/2014 | |
|--|--|--|-----------------|--|--------------------|
| | PROVIDER OR SUPPLIER RT HOME HEALTH SUMMARY S | | 1815 S | ADDRESS, CITY, STATE, ZIP CODE B PLATE STREET MO, IN 46902 PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX TAG | ` | ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION DATE |
| | (x) Any safety against injury. (xi) Instructions referral. (xii) Therapy mo treatment. (xiii) Any other agased on clinical review and interestive and interest | mitations. rmitted. equirements. s and treatments. measures to protect for timely discharge or dalities specifying length of propriate items. If record and policy view, the agency failed to of care covered all safety as an accurate plan of the "Do Not Resuscitate" for home visit patients tential for patient harm and the ability to affect all advance directives, the plan of care was sysician familiar with the for patient harm, and therapy orders included fying length of treatment as reviewed of patient vices with the potential atients receiving therapy for the plan of the potential atients receiving therapy for the plan of the potential atients receiving therapy for the plan of the potential atients receiving therapy for the plan of the potential atients receiving therapy for the plan of the potential atients receiving therapy for the plan of the potential atients receiving therapy for the plan of the potential atients receiving therapy for the plan of | N000524 | G159/N524-100% of all active patients were reviewed by the QI manager. A process was developed and each active chart was reviewed to ensure the DNR status was correct. Any chart found that did no have correct DNR/Code status was corrected by writing an MD order or clarification. A list of active patients was compiled to track the audit and ensure correct code status. This has been completed as of July 7, 14. The DON and ADON will be responsible for orientation and education of staff. 20% of charts will be audited by the QI manager for the next two months to ensure orders are present on meet regulations for the medical plan of care and then quarterly. The DON, ADON, or QI manager will be responsible to ensure this deficience and the corrective actions are completed by July 13, 14. | ot f i d e |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 84 of 111

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION 00 | (X3) DATE COMPL | | |
|---|----------------------|--|------------|---------------|---|--------|--------------------|
| 111121211 | or condition. | 157631 | | LDING | | 06/13/ | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIER | R | | | PLATE STREET | | |
| COMFO | RT HOME HEALTH | LLC | | KOKON | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| TAG | | for the certification | | TAG | | | DATE |
| | 1 | hrough 5/15/14. The | | | | | |
| | _ | did not evidence a "Do | | | | | |
| | | order. The principal | | | | | |
| | diagnosis listed | • • | | | | | |
| | Gastrostomy. | | | | | | |
| | | | | | | | |
| | | Smart Scribe Medical | | | | | |
| | , | are)/485 Worksheet CM- | | | | | |
| | | completed by registered | | | | | |
| | | ployee G, indicated both | | | | | |
| | | d Do not resuscitate had | | | | | |
| | | t a later date the Do not | | | | | |
| | | een errored out by | | | | | |
| | the error out. | date was not present on | | | | | |
| | the error out. | | | | | | |
| | B. The phys | sician orders for the | | | | | |
| | certification peri | od 5/16/14 through | | | | | |
| | 7/14/14 states, "0 | CODE STATUS: Do not | | | | | |
| | resuscitate." The | e principal diagnosis is | | | | | |
| | Dysphagia and o | orophargnyeal. | | | | | |
| | C. The Hon | ne Health Aide | | | | | |
| | | et dated 3/17/14 and | | | | | |
| | _ | t have a place to mark a | | | | | |
| | | ent is to be resuscitated, | | | | | |
| | _ | to make their own | | | | | |
| | decision. | | | | | | |
| | D. On 5/12 | /14 at 5:30 PM, the | | | | | |
| | | therapist (ST), Employee | | | | | |
| | _ | patient and re-certified | | | | | |
| | | ise "Patient demonstrates | | | | | |
| | l ine patient becat | I diffin definentiated | | | | | İ |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 85 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPI A. BUILDING | E CONSTRUCT | ΠΟΝ | (X3) DATE COMPL | | |
|--|---|--|--------------------|---|---|--------|----------------------------|
| | | 157631 | B. WING | | | 06/13/ | 2014 |
| | PROVIDER OR SUPPLIER | | 181 | EET ADDRESS, 5 S PLATE KOMO, IN 4 | | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAC | X (EAC) | PROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE -REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | | ngeal dysphasia resulting by mouth) status. " | | | | | |
| | Alternate Directors, indicated a comade that put a lithe 485/Plan of Company picked Resuscitate codi the POC/485 as The patient is replayed been going 5/16/14 till today | or of Nursing, Employee ding error had been Do Not Resuscitate on Care. The software up the Do Not ng. The physician signed a Do Not Resuscitate. ally a full code. Staff to the home from y (6/13/14) under the atient was a Do Not | | | | | |
| | Resuscitate State DNR order will primary physicia originated during stay, a new orde use by the home | | | | | | |
| | physician and da prescription order use anticoagular milligrams subcr "post op [after su therapy]: Strict | ten by an orthopedic atted 5/13/14. The ered Lovanox [short term at to prevent clotting] 40 attaneous for 10 days, argery] P.T [physical TTWB [toe touch weight ter extremity, hip | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 86 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | A. BUILI | DING | NSTRUCTION 00 | (X3) DATE COMPL 06/13 / | ETED | |
|--|----------------------|--|---------|----------------|---|--------|------------|
| | | | B. WING | | DDRESS, CITY, STATE, ZIP CODE | 30/10/ | |
| NAME OF I | PROVIDER OR SUPPLIER | t . | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | | O, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDENCE N. A.V. OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | P | REFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | ot complainant with | | | | | |
| | | estriction, bed to chair | | | | | |
| | | aily dressing changes, left | | | | | |
| | hip with foam ta | pe." | | | | | |
| | Δ The | record included a plan of | | | | | |
| | | fication period 5/15/14 | | | | | |
| | | start of care 5/15/14, | | | | | |
| | | gnatures on the plan of | | | | | |
| | | attending listed on the | | | | | |
| | | the name of the nurse | | | | | |
| | * | m signed the plan of | | | | | |
| | _ | of care failed to include | | | | | |
| | the directions red | | | | | | |
| | orthopedic physi | ician and the lovenox. | | | | | |
| | | | | | | | |
| | - | one interview with a | | | | | |
| | • | f the clinic on 6/13/14 at | | | | | |
| | 12:15 PM indica | | | | | | |
| | | ployee R, signed the | | | | | |
| | | care and the physician | | | | | |
| | • | n of care had never | | | | | |
| | _ | tient. The physician | | | | | |
| | | edical director for the Center in Kokomo and the | | | | | |
| | | | | | | | |
| | nurse practitione | seen in the clinic by the | | | | | |
| | nuise praemione | A. | | | | | |
| | Clinical record | d # 1, start of care | | | | | |
| | | d a medical plan of care | | | | | |
| | for the certificati | ion period 5/23/14 to | | | | | |
| | | lers for physical therapy | | | | | |
| | | e and treat by week 2 of | | | | | |
| | the certification | period. The clinical | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 87 of 111

PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING | 00 | | E SURVEY PLETED | |
|---|--|---|---------------------|--|--------------------|----------------------------|
| | | 157631 | B. WING | | - 06/1 | 3/2014 |
| | PROVIDER OR SUPPLIER | | 1815 S | ADDRESS, CITY, STATE, ZIP C PLATE STREET 10, IN 46902 | ODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE |
| | completed on 5/2 were provided or clinical record fa physician orders | I the P.T. evaluation was 28/14 and treatments in 6/3/14 and 6/6/14. The ided to evidence specific for the treatments or used and the length of | | | | |
| | physician and da Lovenox [short t injectable antico clotting] 40 milli 10 days, "post op Strict TTWB [too left lower extrem not complainant restriction, bed to daily dressing ch tape." The recor therapist comple 5/23/14 and treat May 23, 27, and 2014. The clinical evidence physici | tten by an orthopedic ted 5/13/14, that ordered erm use, subcutaneous ragulant to prevent grams subcutaneous for a [after surgery] P.T.: the touch weight bearing be chair transfers only, ranges, left hip with foam devidenced the physical ted the evaluation on tements were provided on 29 and June 3 and 5, and record failed to an orders for the idalities to be used and | | | | |
| N000537 | shall provide nursi | The home health agency | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 88 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|----------------------|------------------------------|---------|--------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | | PLATE STREET | | |
| COMFO | RT HOME HEALTH | LLC | | | MO, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | care as follows: | ce with the medical plan of | | | | | |
| | | ew and review of clinical | NOC | 00537 | G170/N537-100 % of charts will be | | 07/13/2014 |
| | | cy, the agency failed to | 1100 | ,0557 | audited by DON, ADON or QI | | 07/13/2011 |
| | 1 | ng services were provided | | | manager related to MD orders and | | |
| | | - | | | POC orders/modifications/additions | ; | |
| | | e plan of care in 3 of 12 | | | by July 11, 14. Staff was given a plar | 1 | |
| | | reviewed (1, 5, and 12) | | | of correction inservice notice that | | |
| | 1 | al to effect all patients | | | instructed them on contacting the | | |
| | receiving nursin | g services. | | | MD with POC orders/modifications/additions. The | , | |
| | 1 | | | | disciplines were also told verbally of | | |
| | Findings: | | | | this need. Disciplines will ensure | | |
| | | | | | that they perform care under the | | |
| | | rd 12, start of care | | | MD order. Staff will be educated pe | r | |
| | 5/19/14, failed to | o evidence a plan of care | | | plan of correction inservice notice | | |
| | signed by the ph | ysician at the time of the | | | on consulting with the MD for every | ′ | |
| | survey on 6/13/1 | 4. A verbal order was | | | aspect of care to be provided and | | |
| | obtained 5/19/14 | for Home care | | | that care cannot deviate from a | | |
| | evaluation and t | reat skilled nurse 2 times | | | current order for Tx or meds. A new order must be obtained for any | | |
| | a week times 1 v | week, physical therapy | | | change. The MD will be contacted | | |
| | evaluation and to | reat and occupational | | | for all initial and ongoing treatment | | |
| | therapy evaluation | on and treat. The | | | orders. The DON and ADON will be | | |
| | | I the verbal order | | | responsible for orientation and | | |
| | | nical record evidenced | | | education of staff. 20% of charts wil | I | |
| | | its without orders week 3 | | | be audited by the QI manager for | | |
| | | week 4 on 6/2/14. | | | the next two months to ensure | | |
| | on 3/23/11 and | Veck 1 off 6/2/11. | | | orders are present to meet regulations for the medical plan of | | |
| | 2 The undeted | nolicy titled "Modication | | | care and then quarterly. The DON, | | |
| | | policy titled "Medication | | | ADON, or QI manager will be | | |
| | | Guidelines" number 2.57 | | | responsible to ensure this deficience | y | |
| | · · | ics a. Nurses are only | | | and the corrective actions are | | |
| | | e the initial dose in the | | | completed by July 13, 14. | | |
| | | ledge of the physician | | | | | |
| | - | ers for treatment of a | | | | | |
| | reaction are prov | vided by the physician | | | | | |
| | The nurse should | d observe the patient / | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 89 of 111

PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | | |
|---|----------------------|--|---------------------|------------|---|-------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPI | |
| | | 157631 | B. WIN | | | 06/13 | /2014 |
| NAME OF I | PROVIDER OR SUPPLIER | t | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| 0014501 | | 11.0 | 1815 S PLATE STREET | | | | |
| COMFOR | RT HOME HEALTH | LLC | | KOKOW | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | • | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | · · · · · · · · · · · · · · · · · · · | | TAG | BEHREIMET | | DATE |
| | 1 | action for at least 30 | | | | | |
| | | e dose is given | | | | | |
| | | cation administration by | | | | | |
| | | patient / client's clinical | | | | | |
| | • | e: a. medication name, | | | | | |
| | | . medication date and | | | | | |
| | | re the patient / client for | | | | | |
| | | ts and document, 1. | | | | | |
| | | cian order for medication | | | | | |
| | | 2. Verify the date and | | | | | |
| | | nedication administration | | | | | |
| | | documentation in the | | | | | |
| | patient / client re | ecord." | | | | | |
| | 2 (1: : 1 | 11 (000) | | | | | |
| | | rd 1, start of care (SOC), | | | | | |
| | evidenced a plan | | | | | | |
| | _ | od 5/23/14 through | | | | | |
| | | lers for skilled nurse once | | | | | |
| | _ | weeks. Employee B | | | | | |
| | | of care dated 5/21/14 | | | | | |
| | _ | oal order was received for | | | | | |
| | | 5/21/14. The record | | | | | |
| | | e the verbal order | | | | | |
| | | record included a two | | | | | |
| | ^ ~ | ed 5/21/14 which was | | | | | |
| | | yee B. The referral did | | | | | |
| | | bal order as written on | | | | | |
| | the plan of care. | | | | | | |
| | | isisaa saadaa deeest | | | | | |
| | _ | nysician order dated | | | | | |
| | 5/23/14, written | | | | | | |
| | | al order was obtained | | | | | |
| | | ng physician for home | | | | | |
| | health care evalu | ate and treat, skilled | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 90 of 111

PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | INSTRUCTION | (X3) DATE | | |
|---|---------------------|------------------------------|------------|-------------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | G | | 06/13/ | 2014 |
| NAME OF F | ROVIDER OR SUPPLIER | - | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | KOKON | 1O, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | nurse one visit d | uring week one. | | | | | |
| | | | | | | | |
| | B. The | record evidenced the | | | | | |
| | occupational the | rapist completed an | | | | | |
| | assessment on 5/ | 31/14 and completed | | | | | |
| | additional visits | on June 2 and June 4, | | | | | |
| | 2014. The recor | d failed to evidence a | | | | | |
| | physicians order | for the occupational | | | | | |
| | visits and the ser | • | | | | | |
| | | • | | | | | |
| | 4. Clinical recor | rd 5, start of care 4/16/14, | | | | | |
| | | cal plan of care for the | | | | | |
| | | od 4/16/14 through | | | | | |
| | _ | ers for skilled nursing to | | | | | |
| | | 2 hours 4 times a week | | | | | |
| | _ | 1 2 hours a day - 3 days a | | | | | |
| | • | s to assess / evaluate all | | | | | |
| | | ound care - right inner | | | | | |
| | | with normal saline, | | | | | |
| | • | nd cover with mepilex | | | | | |
| | 11 3 0 | d care - left inner buttock | | | | | |
| | - | ormal saline, apply black | | | | | |
| | | nd vacuum at 125 | | | | | |
| | | every 3 days. The plan of | | | | | |
| | | IV medication order for | | | | | |
| | | | | | | | |
| | | grams to be administered | | | | | |
| | • | r six days. The record | | | | | |
| | | e a physician was | | | | | |
| | | ound treatment orders and | | | | | |
| | | orders as written on the | | | | | |
| | plan of care. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | A. Skill | led nurse visit note dated | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 91 of 111

PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING B. WING | | | COMPLETED 06/13/2014 | | | |
|---|---------------------|------------------------------|--------|--------|--|---|------------|--|
| | | 157631 | B. WIN | G | | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | | |
| COMFOR | RT HOME HEALTH | LLC | | | PLATE STREET 10, IN 46902 | | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE APPROPRI | E | COMPLETION | |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE | |
| | _ | ed by employee P, a | | | | | | |
| | - | l nurse stated, "IV ATB | | | | | | |
| | | er order PICC | | | | | | |
| | - | oyee C completed a | | | | | | |
| | | t at the same time and | | | | | | |
| | | Wound Visit Note | | | | | | |
| | | h identified the left | | | | | | |
| | wound was with | • | | | | | | |
| | _ | s not specific which, 6.0 | | | | | | |
| | | o'clock, tunneling and | | | | | | |
| | / or undermining | | | | | | | |
| | | he comprehensive | | | | | | |
| | | documentation the left | | | | | | |
| | wound was dress | sed with green foam | | | | | | |
| | verse the black for | oam as written on the | | | | | | |
| | plan of care prior | r to applying the wound | | | | | | |
| | vacuum. The vi | sit note and clinical | | | | | | |
| | record failed to e | vidence the physician | | | | | | |
| | was notified abou | ut the tunneling / | | | | | | |
| | undermining and | the record failed to | | | | | | |
| | evidence a physi- | cian order for green | | | | | | |
| | foam to be used | with the wound vacuum. | | | | | | |
| | The visit note an | d clinical record failed to | | | | | | |
| | evidence patient | / caregiver education, | | | | | | |
| | measurement of | learning, observation of | | | | | | |
| | caregiver / patier | nt technique for the PICC | | | | | | |
| | care, IV administ | tration, wound care | | | | | | |
| | procedures for le | evel of education, any | | | | | | |
| | deficits and educ | ation needs, and a clear | | | | | | |
| | delineation which | h tasks the patient / | | | | | | |
| | caregiver was co | mpetent to complete. | | | | | | |
| | B. Skill | ed nurse visit note dated | | | | | | |
| | 4/18/14 complete | ed by employee C, a RN, | | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 92 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | (X2) MUI A. BUILE | | NSTRUCTION 00 | (X3) DATE : COMPL | ETED | |
|--|--|--|---------|--------------------|---|--------|----------------------------|
| | | 157631 | B. WING | | | 06/13/ | 2014 |
| | PROVIDER OR SUPPLIER | | | 1815 S I | DDRESS, CITY, STATE, ZIP CODE PLATE STREET O, IN 46902 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | P | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | (X5) COMPLETION DATE |
| TAG | indicated a blood from the PICC a flushed and lock visit note failed administered the to include a wou evidence a body line was drawn t note and the syst was left blank. C. Skill 4/19/14 complet "Removed green with normal salit foam." The door evidence an assessment of all portion of the nublank. D. Skill 4/21/14 complet | d draw was obtained nd the PICC line was ed with Heparin. The | | TAG | DEFICIENCY) | | DATE |
| | blank with a line evidence an asse access, and faile | te portion of the note was e drawn through, failed to essment of the PICC d to assess the wound on t buttock. The note | | | | | |
| | the left buttock vacuum was atta | essing to the wound on was changed and wound sched. The visit note the laboratory draw | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 93 of 111

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | | |
|---|----------------------|------------------------------|------------|------------|---|--------|------------|
| AND PLAN | OF CORRECTION | | A. BUI | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | | | 06/13/ | /2014 |
| NAME OF I | PROVIDER OR SUPPLIER | t | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| 0014505 | | 11.0 | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | KUKUIV | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | written on the plan of | | | | | |
| | care. | | | | | | |
| | E 01.11 | 1 | | | | | |
| | | ed nurse visit note dated | | | | | |
| | _ | ed by employee C | | | | | |
| | I = | he wound on the left and | | | | | |
| | | und was tunneling or | | | | | |
| | _ | specified] at 11 o' | | | | | |
| | | mentation evidenced the | | | | | |
| | 1 | wound dressing, applied | | | | | |
| | ~ | e wound bed, and | | | | | |
| | reattached the w | ound vacuum. | | | | | |
| | | | | | | | |
| | | ed nurse visit note dated | | | | | |
| | | ted by employee P, that | | | | | |
| | | wounds were not | | | | | |
| | | the visit and stated, | | | | | |
| | "Assisted patient | | | | | | |
| | - | he plan of care indicated | | | | | |
| | | syn was ordered for 6 | | | | | |
| | | 4/16/14. The record | | | | | |
| | _ | why the patient was | | | | | |
| | | biotic on the 7th day | | | | | |
| | following the sta | art of the antibiotic. | | | | | |
| | | | | | | | |
| | | led nurse visit note dated | | | | | |
| | _ | ted by employee P, failed | | | | | |
| | | was provided to the | | | | | |
| | 1 | ght and an assessment of | | | | | |
| | | only the wound on the left | | | | | |
| | | rithin the notes - noted | | | | | |
| | the dressing was | changed. | | | | | |
| | | | | | | | |
| | H. Skill | led nurse visit note dated | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 94 of 111

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157631 | | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 06/13 / | ETED | |
|--|---|--|----------|---------------------|--|------|----------------------------|
| | PROVIDER OR SUPPLIER | | p. w.i.v | 1815 S | ADDRESS, CITY, STATE, ZIP CODE PLATE STREET 10, IN 46902 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | .TE | (X5) COMPLETION DATE |
| | to evidence care wound on the rig either wound; on | ted by employee P, failed was provided to the ght and an assessment of ally the wound on the left within the notes which ag was changed. | | | | | |
| | 4/29/14, complete evidenced the wow was healed and to now 17.0 centime width, no depth of undermining / to was measured to and a blood serut from the PICC. documented the packed with green. | ed nurse visit note dated ted by employee P, bound on the right buttock the wound on the left was eters in length X 4.0 cm was documented and unneling [not specified] be 6.0 cm at 11 o'clock, cm sample was collected. The employee wound on the left was en foam and not the black on the plan of care. | | | | | |
| | 5/1/14, complete indicated a dress on the left was cowas placed in the | ed nurse visit note dated of by employee P, ing change to the wound completed and green foam e wound bed, not the ritten on the plan of care. | | | | | |
| | 5/3/14, complete indicated a dress on the left was cowas placed in the | led nurse visit note dated and by employee P and ing change to the wound completed and green foam the wound bed, not the ritten on the plan of care. | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 95 of 111

PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | | |
|---|----------------------|------------------------------|------------|------------|---|-------|------------|
| AND PLAN | OF CORRECTION | | A. BUII | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | | | 06/13 | 2014 |
| NAME OF I | PROVIDER OR SUPPLIER | t | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| 0014505 | ST LIGNE LIENT TH | 11.0 | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | KOKOW | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCI) | | DATE |
| | I C1-:11 | | | | | | |
| | | ed nurse visit note dated | | | | | |
| | | ed by employee C stated, | | | | | |
| | | I from overnight stay at | | | | | |
| | _ | o have abscess I & D | | | | | |
| | - | inage]. New wound and | | | | | |
| | IV antibiotics." | | | | | | |
| | | ound on the left buttock | | | | | |
| | · · | gth X 3.5 cm width X 0.3 | | | | | |
| | _ | e wound on the right was | | | | | |
| | | 1.5 cm length X 1.75 cm | | | | | |
| | - | rd included a Physician | | | | | |
| | | greens Infusion that listed | | | | | |
| | | Invanz 1 gram / 100 mL | | | | | |
| | _ | ne] Mini Bag Plus" and | | | | | |
| | | were to "Activate bag as | | | | | |
| | _ | each dose to dissolve | | | | | |
| | | infuse Invanz 1 GM / | | | | | |
| | | our (100 mL / hr) once | | | | | |
| | | er PICC line via gravity | | | | | |
| | | The documentation for the | | | | | |
| | | it failed to evidence a full | | | | | |
| | body systems as: | | | | | | |
| | assessment of th | e PICC line was | | | | | |
| | _ | g the visit. The note | | | | | |
| | · · | ed on new antibiotic." | | | | | |
| | The record failed | d to evidence orders for | | | | | |
| | | peds or that the attending | | | | | |
| | | onsulted regarding the | | | | | |
| | new IV antibioti | c orders and wound care. | | | | | |
| | M. Skil | led nurse visit note dated | | | | | |
| | 5/8/14 indicated | the wound of the left | | | | | |
| | buttock was clea | insed and green foam was | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 96 of 111

| AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | A. BUILDING B. WING | | | COMPL | COMPLETED 06/13/2014 | |
|--|--|--|----------------|---------------------|--|-----------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | <i>p.</i> will | 1815 S | DDRESS, CITY, STATE, ZIP CODE PLATE STREET IO, IN 46902 | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | applied to the we applied. The wo was cleansed wi wet to dry dressi record failed to order for the wood N. Skill 5/10/14 indicated buttock was cleansed with wet to dry dressi record failed to do order for the wood O. The the PICC access during week four period. Skilled completed on M. The documentatt failed to evidence PICC access and record failed to evidence piccord f | bund bed and vacuum bund on the right buttock th normal saline and a ng was applied. The evidence a physician und care provided. Ited nurse visit note dated d the wound of the left unsed and green foam was bund bed and vacuum bund on the right buttock th normal saline and a ng was applied. The evidence a physician und care provided. The evidence a physician und care provided. The evidence dressing was changed or of the certification unurse visits were any 7, 8, and 10, 2014. The evidence and the evidence and | | | | | |
| | indicated, when obtained from th | at 2:08 PM, employee A asked, the referral is e office nurse and that was to write the name of | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 97 of 111

PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | | A. BUII | | 00 | COMPL 06/13/ | ETED |
|---|---------------------|------------------------------|---------|--------|--|-----------------|------------|
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COMFOR | RT HOME HEALTH | LLC | | | PLATE STREET 10, IN 46902 | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | Ē | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | _ | the assessment which | | | | | |
| | - | y contacted the attending | | | | | |
| | physician for trea | atment orders. | | | | | |
| | 7 On 6/12/14 at | 1:15 PM, employee O | | | | | |
| | | e only places the name of | | | | | |
| | | the form but he does not | | | | | |
| | • | cian for treatment orders | | | | | |
| | | e staff obtained the | | | | | |
| | | When asked to clarify, | | | | | |
| | | cated he / she was | | | | | |
| | | nitial order obtained for | | | | | |
| | the evaluation of | | | | | | |
| | the evaluation of | the patient. | | | | | |
| | 8. During a face | to face interview on | | | | | |
| | • | AM, employee M, | | | | | |
| | indicated he / she | | | | | | |
| | | ssessments and admitted | | | | | |
| | • | e health services. He / | | | | | |
| | | office staff obtain the | | | | | |
| | | urse in the field does not | | | | | |
| | | orders to treat the | | | | | |
| | | ere was a concern or | | | | | |
| | • | e indicated when the | | | | | |
| | | he name of the attending | | | | | |
| | | assessment document it | | | | | |
| | | to the initial order to | | | | | |
| | - | ent for home health | | | | | |
| | - | ot indicating the disciple | | | | | |
| | | ysician for treatment | | | | | |
| | | put in the development | | | | | |
| | of the plan of car | | | | | | |
| | or and plant of car | | | | | | |
| | 9. During a telep | ohone interview on | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 98 of 111

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MU | LTIPLE CO | INSTRUCTION | (X3) DATE S | | |
|---|---------------------|---|-----------|-------------|---|-----------------|------------|
| AND PLAN | OF CORRECTION | 157631 | A. BUIL | DING | 00 | COMPL 06/13/ | |
| | | 137631 | B. WINC | | | 00/13/ | 2014 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| COMFOR | RT HOME HEALTH | LLC | | | PLATE STREET 10, IN 46902 | | |
| (X4) ID | SUMMARY ST | FATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | 1 | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | E | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | PM, employee N | | | | | |
| | indicated the init | ial physician order to | | | | | |
| | evaluate for hom | e health services was | | | | | |
| | completed by off | fice nurse named | | | | | |
| | employee F. Wh | nen asked if he / she calls | | | | | |
| | the physician for | initial treatment orders, | | | | | |
| | | cated he / she does not | | | | | |
| | | n for treatment orders | | | | | |
| | | the comprehensive | | | | | |
| | | she indicated the plan | | | | | |
| | of care is written | _ | | | | | |
| | physician and if | the physician wishes to | | | | | |
| | | s then they may at that | | | | | |
| | time. | s then they may at that | | | | | |
| | time. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| N000541 | 410 IAC 17-14-1(a | a)(1)(B) | | | | | |
| | Scope of Services | | | | | | |
| | | (1)(B) Except where | | | | | |
| | | d to therapy only, for | | | | | |
| | | ce in the home health red nurse shall do the | | | | | |
| | following: | red harse shall do the | | | | | |
| | (B) Regularly reev | valuate the patient's | | | | | |
| | nursing needs. | | | | | | |
| | | l record review and | N00 | 0541 | G172/N541-100 % of active charts | | 07/13/2014 |
| | observation, the | agency failed to ensure | | | will be reviewed by DON, ADON, or | | |
| | the registered ide | entified and addressed | | | QI Manager to ensure that no safety issue is present in current charts. | ' | |
| | safety concerns i | n the patients home in 1 | | | Education to pt/family/caregiver on | | |
| | of 6 home visits | observed (#1) creating | | | safety is to be completed by skilled | | |
| | | | | | , | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 99 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|------------------------------|------------------|--------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 00 | COMPL | ETED |
| | | 157631 | B. WING | | | 06/13/ | 2014 |
| | | | B. WINC | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | KOKOMO, IN 46902 | | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | 1 | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | the potential for | the patient to fall and | | | staff. Staff will be instructed to | | |
| | harm themselves | S. | | | record safety issues on | | |
| | | | | | comprehensive assessment or visit | | |
| | The findings inc | lude: | | | note and will be re-instructed on th | e | |
| | | | | | incident reporting policy. The DON | | |
| | 1. On 6/11/14 at 4:30 PM, patient 1 was | | | | and/or ADON will instruct the | | |
| | | • • | | | clinical staff on safety issue/inciden | | |
| | | nome. The patient lives | | | reporting. The agency will ensure al pts are regularly evaluated and | ı | |
| | | style home with private | | | re-evaluated following any incident | | |
| | | the day. The home visit | | | regarding pt safety, or any health | | |
| | was for physical | therapy. The patient | | | concern. When the agency is aware | | |
| | indicated the pat | tient had fallen off the | | | of a safety concern or incident, an | | |
| | toilet extension | earlier in the day. The | | | incident report is completed which | | |
| | connector to the | toilet extension had | | | includes notifying the MD of the | | |
| | given loose from | n the toilet and the | | | incident. Staff are instructed to | | |
| | _ | llen to one side. The | | | complete the incident report and | | |
| | | ad caught the patient | | | notify the MD. Disciplines ongoing | | |
| | | e floor. The patient did | | | safety assessment is to be addresse | d | |
| | _ | • | | | on each visit. Ongoing chart audits | | |
| | | hurt. The paid attendant | | | are reviewed with quarterly record | | |
| | | anyone. The patient had | | | review by the QI manager. This will be completed by July 13, 14. | | |
| | | come and put on | | | be completed by July 13, 14. | | |
| | | es on the toilet. The | | | | | |
| | handles attached | directly to the back of | | | | | |
| | the toilet through | h the lid holes. Upon | | | | | |
| | inspection, both | the new handles and the | | | | | |
| | toilet extension | are loose and tilt from | | | | | |
| | | e agency nurse stayed in | | | | | |
| | | and did not come to the | | | | | |
| | _ | e toilet inspection. The | | | | | |
| | | st assistant did come in. | | | | | |
| | physical merapis | or assistant uiu cuine iii. | | | | | |
| | On 6/11/14 | at 5:15 PM, the physical | | | | | |
| | | nt, Employee J, indicated | | | | | |
| | - | I the toilet extension | | | | | |
| | | y attached to the toilet. | | | | | |
| | Were not secure | y attached to the tollet. | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 100 of 111

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157631 | | A. BUILDING B. WING | 00 | COM | e survey pleted 3/2014 | |
|---|--|--|---------------------|---|------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | STREET A 1815 S | DDRESS, CITY, STATE, ZIP COPLATE STREET O, IN 46902 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| | | t would try to get up and on one side than the d tilt. | | | | |
| | evidenced a plant certification period for the certification period a week for eight to evaluate and to the certification which is evaluate and to the certification which is evidentify the lack patient's bathroom been developed to falls. The comprehevidenced the particle of the particle for falls with the certification of | rd 1, start of care (SOC) of care for the od 5/23/14 through ers for skilled nurse once weeks, physical therapy reat, and occupational ate and treat by the he record failed to of safety features in the m and that a plan had to prevent and reduce thensive assessment atient was assessed to be with a score of 11. was determined by the ent form to be at high risk | | | | |
| N000542 | services are limite purposes of practi setting, the register following: | , , , , , | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 101 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CC | ONSTRUCTION | (X3) DATE | | |
|--|-----------------------|------------------------------|------------|-------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 157631 | B. WIN | G | | 06/13/ | 2014 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | - | |
| TWINE OF I | KO VIDEK OK SOIT EIEN | | | 1815 S | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | KOKON | ЛО, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | Based on clinica | l record and policy | N00 | 00542 | G173/N542-100% of all active | | 07/13/2014 |
| | review and inter | view, the agency failed to | | | patients were reviewed by the QI | | |
| | ensure the regist | ered nurse initiated an | | | manager. A process was developed | | |
| | accurate plan of | care in 2 of 12 records | | | and each active chart was reviewed | | |
| | reviewed with th | e potential for patient | | | to ensure the DNR status was correct. An active patient list was | | |
| | | ient and the ability to | | | compiled to track the audit and | | |
| | affect all the pati | • | | | ensure correct code status. Any | | |
| | put | - (| | | chart found that did not have | | |
| | Findings: | | | | correct DNR/Code status was | | |
| | i mamgs. | | | | corrected by writing an MD order o | f | |
| | Clinical recor | rd 10 avidanced | | | clarification. A list was compiled to | | |
| | | | | | track the audit and ensure correct | | |
| | 1 1 | for the certification | | | code status. This has been | | |
| | 1 ^ | nrough 5/15/14. The | | | completed as of July 7, 14. The DON and ADON will be responsible for | l | |
| | | did not evidence a Do | | | orientation and education of staff. | | |
| | | order. The principal | | | 20% of charts will be audited by the | ! | |
| | diagnosis listed i | | | | QI manager for the next two month | | |
| | _ | he plan of care indicated | | | to ensure orders are present to | | |
| | the patient was a | Do Not Resuscitate | | | meet regulations for the medical | | |
| | status. | | | | plan of care and then quarterly. The | 2 | |
| | | | | | DON, ADON, or QI manager will be | | |
| | A. A 2010 S | Smart Scribe Medical | | | responsible to ensure this deficience and the corrective actions are | У | |
| | POC (Plan of Ca | re)/485 Worksheet CM- | | | completed by July 13, 14. | | |
| | 3 dated 5/13/14 | completed by registered | | | completed by July 13, 14. | | |
| | nurse (RN), Emp | ployee G, indicated both | | | | | |
| | the Full code and | d Do not resuscitate had | | | | | |
| | been marked. A | t a later date the Do not | | | | | |
| | resuscitate had b | een errored out by | | | | | |
| | | date was not present on | | | | | |
| | the error out. | and has her process on | | | | | |
| | and critici dut. | | | | | | |
| | R The nhw | sician orders for the | | | | | |
| | | od 5/16/14 through | | | | | |
| | • | es "CODE STATUS: Do | | | | | |
| | | S CODE STATUS, DO | | | | | |
| | not resuscitate." | | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 102 of 111

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | | NSTRUCTION 00 | (X3) DATE COMPL | ETED |
|--------------------------|--|--|----------------------|--------------------|--|--------------------|----------------------------|
| | | 157631 | B. WING | | | 06/13/ | 2014 |
| | PROVIDER OR SUPPLIER | | | 1815 S F | DDRESS, CITY, STATE, ZIP CODE PLATE STREET O, IN 46902 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | P. | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | Assignment She 5/13/14 does not | ne Health Aide et dated 3/17/14 and have a place to mark a le, leaving the aide to decision. | | | | | |
| | Alternate Directors, indicated a comade that put a latthe 485/Plan of Company picked Resuscitate codifiction the POC/485 as a The patient is real have been going 5/16/14 till today. | or of Nursing, Employee ding error had been Do Not Resuscitate on Care. The software up the Do Not ng. The physician signed a Do Not Resuscitate. ally a full code. Staff to the home from y (6/13/14) under the atient was a Do Not | | | | | |
| | Resuscitate State DNR order will primary physicial originated during stay, a new order use by the home 2. Clinical recon included a media certification period/16/14 with ord provide services | g the patient's hospital r must be obtained for | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 103 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | | |
|--|---|------------------------------|------------|------------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLI | |
| | | 157631 | B. WIN | | | 06/13/ | 2014 |
| NAME OF I | PROVIDER OR SUPPLIER | 3 | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | PLATE STREET | | |
| COMFO | RT HOME HEALTH | LLC | | KOKON | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | eks to assess / evaluate | | | | | |
| | all body systems, wound care - right inner buttock, cleanse with normal saline apply alginate and cover with mepilex daily, | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | t inner buttock - cleanse | | | | | |
| | | ne apply black sponge | | | | | |
| | | um at 125 mmHg and | | | | | |
| | | days. The plan of care | | | | | |
| | | nedication order zosyn | | | | | |
| | | to be administered every | | | | | |
| | | ays. The record included | | | | | |
| | 1 * * | r dated 4/16/14 for home | | | | | |
| | | and treat, written by | | | | | |
| | | :30 PM. The record | | | | | |
| | | e a physician was | | | | | |
| | | e wound treatment orders | | | | | |
| | | iotic orders as written on | | | | | |
| | the plan of care. | | | | | | |
| | | | | | | | |
| | A. On a | a document titled "MCD | | | | | |
| | [Medicaid] Skill | ed Care Plan / Nursing | | | | | |
| | Visit Note" of th | e same date, 4/16/14, | | | | | |
| | stated, "Discharg | ge from acute hosp | | | | | |
| | [hospital] with o | ngoing extensive wound | | | | | |
| | care needs inclu | ding cont. [continuous] | | | | | |
| | IV [intravenous] | therapy - both requiring | | | | | |
| | SN." The docu | mentation indicated the | | | | | |
| | plan was for the | skilled nurse to provide | | | | | |
| | services 2 hours | 4 times a week for 2 | | | | | |
| | weeks, then 2 ho | ours a day - 3 days a week | | | | | |
| | for 7 weeks; wo | und care per wound | | | | | |
| | vacuum, to be changed every 3 days; a | | | | | | |
| | laboratory draw, | a basic metabolic profile | | | | | |
| | on 4/18/14, 4/21 | /14, and 4/23/14; and to | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 104 of 111

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE COMPL | | |
|---|----------------------|------------------------------|------------|------------|---|--------|------------|
| ANDILAN | OF CORRECTION | 157631 | | LDING | 00 | 06/13/ | |
| | | 107001 | B. WIN | | PRESIDENCE CONTROL OF CORP. | 00/10/ | 2014 |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | | ADDRESS, CITY, STATE, ZIP CODE PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | | 10, IN 46902 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | · · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | per protocol with sterile | | | | | |
| | | every 7 days. The | | | | | |
| | | evidence a physician was | | | | | |
| | | ders received for the plan | | | | | |
| | | RN which included | | | | | |
| | | for the IV antibiotics, | | | | | |
| | | ers, and orders for follow | | | | | |
| | 1 | ow hemoglobin and | | | | | |
| | potassium as not | ted on the comprehensive | | | | | |
| | assessment. | | | | | | |
| | | | | | | | |
| | B. Skill | led nurse visit notes dated | | | | | |
| | 5/1/14 and 5/3/1 | 4 completed by | | | | | |
| | employee P indi | cated a dressing change | | | | | |
| | to the wound on | the left was completed | | | | | |
| | and green foam | was placed in the wound | | | | | |
| | bed, not the blac | k foam as written on the | | | | | |
| | plan of care. Th | e record failed to | | | | | |
| | evidence a chang | ge to the plan of care. | | | | | |
| | | | | | | | |
| | C. Skill | led nurse visit note dated | | | | | |
| | 5/7/14 complete | d by employee C stated, | | | | | |
| | _ | I from overnight stay at | | | | | |
| | | o have abscess I & D | | | | | |
| | _ | inage]. New wound and | | | | | |
| | IV antibiotics." | | | | | | |
| | | ound on the left buttock | | | | | |
| | was 14.0 cm len | gth X 3.5 cm width X 0.3 | | | | | |
| | | e wound on the right was | | | | | |
| | _ | 1.5 cm length X 1.75 cm | | | | | |
| | | rd included a Physician | | | | | |
| | _ | greens Infusion that listed | | | | | |
| | l ' | Invanz 1 gram / 100 mL | | | | | |
| | | ne] Mini Bag Plus" and | | | | | |
| | 1 10 [Hornial Salli | 10] Tillin Dug I lus allu | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 105 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ULTIPLE CO LDING | NSTRUCTION 00 | (X3) DATE S COMPLE | | |
|--|---|------------------------------|---------------------|---------------|--|---------|------------|
| | | 157631 | B. WIN | | | 06/13/2 | 2014 |
| NAME OF I | PROVIDER OR SUPPLIER | } | • | STREET A | DDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | PLATE STREET | | |
| COMFO | RT HOME HEALTH | LLC | | KOKOM | 1O, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENC!) | | DATE |
| | the instructions "Activate bag as directed prior to each dose to dissolve completely, | | | | | | |
| | then infuse Invanz 1 GM / 100 mL over 1 hour (100 mL / hr) once every 24 hours | | | | | | |
| | | | | | | | |
| | , | a gravity set X 7 days." | | | | | |
| | _ | d to evidence physician | | | | | |
| | | ew wound beds and that | | | | | |
| | | ysician was consulted | | | | | |
| | | w IV antibiotic orders | | | | | |
| | and wound care. | | | | | | |
| | | | | | | | |
| | D. Skil | led nurse visit note dated | | | | | |
| | 5/8/14 indicated | the wound of the left | | | | | |
| | buttock was clea | nnsed and green foam was | | | | | |
| | applied to the w | ound bed and vacuum | | | | | |
| | applied and that | the wound on the right | | | | | |
| | buttock was clea | nsed with normal saline | | | | | |
| | and a wet to dry | dressing was applied. | | | | | |
| | The record failed | d to evidence a physician | | | | | |
| | order for the wo | und care provided. | | | | | |
| | E Skill | led nurse visit note dated | | | | | |
| | | d the wound of the left | | | | | |
| | | ansed and green foam was | | | | | |
| | | ound bed and vacuum | | | | | |
| | | the wound on the right | | | | | |
| | | nsed with normal saline | | | | | |
| | | dressing was applied. | | | | | |
| | - | d to evidence a physician | | | | | |
| | | und care provided. | | | | | |
| | E Duri | ng a face to face interview | | | | | |
| | | :00 AM, employee M, | | | | | |
| | indicated he / sh | | | | | | |
| | mulcated lie / SII | c completed | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | | | TE SURVEY | |
|---|----------------------|------------------------------|-------------|---|-----------|------------|
| AND PLAN | OF CORRECTION | | A. BUILDING | 00 | | PLETED |
| | | 157631 | B. WING | | | 3/2014 |
| NAME OF P | PROVIDER OR SUPPLIEF | | | ADDRESS, CITY, STATE, ZIP C | CODE | |
| COMEC | OT LIONAE LIENI TU | 11.0 | | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLU | KOKON | ло, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF COR | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | | DATE |
| | • | assessments and admitted | | | | |
| | • | e health services. He / | | | | |
| | | e office staff obtain the | | | | |
| | | urse in the field does not | | | | |
| | call for physician | n orders to treat the | | | | |
| | - | ere was a concern or | | | | |
| | question. He/sh | ne indicated when the | | | | |
| | clinician writes t | the name of the attending | | | | |
| | physician on the | assessment document it | | | | |
| | is only referring | to the initial order to | | | | |
| | evaluate the pati | ent for home health | | | | |
| | services and is n | ot indicating that the | | | | |
| | | ed the physician for | | | | |
| | - | and for input in the | | | | |
| | development of | - | | | | |
| | uo voi opinioni or | print of the c | | | | |
| | G Duri | ing a telephone interview | | | | |
| | | :19 PM, employee N | | | | |
| | | tial physician order to | | | | |
| | | ne health services was | | | | |
| | | fice nurse and named | | | | |
| | | hen asked if he / she calls | | | | |
| | | | | | | |
| | | r initial treatment orders, | | | | |
| | _ : | icated that he / she does | | | | |
| | | ician for treatment orders | | | | |
| | | the comprehensive | | | | |
| | | / she indicated the plan | | | | |
| | of care is writter | | | | | |
| | | the physician wishes to | | | | |
| | change the order | s then they may at that | | | | |
| | time. | | | | | |
| | | | | | | |
| | | | | | | |
| N000543 | 410 IAC 17-14-1(a | a)(1)(D) | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 107 of 111

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE | | |
|--|----------------------|---|---------|----------|--|-------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPI | |
| | | 157631 | B. WIN | | | 06/13 | /2014 |
| NAME OF F | DOLUDED OD GLIDDLIED | | - | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | t . | | 1815 S | PLATE STREET | | |
| COMFOR | RT HOME HEALTH | LLC | | KOKON | MO, IN 46902 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | _ | TAG | DEFICIENCY) | | DATE |
| | Scope of Services | | | | | | |
| | | (1)(D) Except where ed to therapy only, for | | | | | |
| | | ce in the home health | | | | | |
| | | ered nurse shall do the | | | | | |
| | following: | | | | | | |
| | | oriate preventive and | | | | | |
| | rehabilitative nurs | ~ . | | | | | |
| | | l record and policy | N00 | 00543 | G175/N543-100% of all active | | 06/13/2014 |
| | | view, the agency failed to | | | patients were reviewed by the QI | | |
| | ensure the regist | ered nurse accurately | | | manager. A process was developed and each active chart was reviewed | | |
| | initiated the "Do | Not Resuscitate" status | | | to ensure the DNR status was | l | |
| | of the 1 of 6 hon | ne visit patients (10) with | | | correct. An active patient list was | | |
| | | patient harm for this | | | compiled to track the audit and | | |
| | _ | bility to affect all the | | | ensure correct code status. Any | | |
| | patients with adv | | | | chart found that did not have | | |
| | P | | | | correct DNR/Code status was | | |
| | Findings: | | | | corrected by writing an MD order of | f | |
| | i mamgs. | | | | clarification. A list was compiled to | | |
| | Clinical recor | rd 10 avridanced | | | track the audit and ensure correct | | |
| | | | | | code status. This has been | d | |
| | | for the certification | | | completed as of July 7, 14. The DOI and ADON will be responsible for | V | |
| | • | hrough 5/15/14. The | | | orientation and education of staff. | | |
| | 1 2 | did not evidence a "Do | | | 20% of charts will be audited by the | 2 | |
| | | order. The principal | | | QI manager for the next two month | | |
| | diagnosis listed | was Attention to | | | to ensure orders are present to | | |
| | Gastrostomy. | | | | meet regulations for the medical | | |
| | | | | | plan of care and then quarterly. The | e | |
| | 2. A 2010 Smar | t Scribe Medical POC | | | DON, ADON, or QI manager will be | | |
| | (Plan of Care)/48 | 85 Worksheet CM-3 | | | responsible to ensure this deficience | :y | |
| | ` ′ | mpleted by registered | | | and the corrective actions are | | |
| | | ployee G, indicated both | | | completed by July 13, 14. | | |
| | | d Do not resuscitate had | | | | | |
| | | t a later date the Do not | | | | | |
| | | een errored out by | | | | | |
| | | • | | | | | |
| | Employee G. A | date was not present on | | | | | |
| | | | 1 | | 1 | | 1 |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 108 of 111

| STATEMENT OF DEFI | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157631 | | LDING | onstruction 00 | (X3) DATE COMPI 06/13 | |
|--|---|--|--|---------------------|--|-----------------------------|--|
| NAME OF PROVIDER OR SUPPLIER COMFORT HOME HEALTH LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1815 S PLATE STREET KOKOMO, IN 46902 | | | | | |
| PREFIX (EAC | 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 B CROSS-REFERENCED TO THE APPROP DEFICIENCY) | (X5) COMPLETION DATE | |
| the error of the error of the error of the error of the error of the error of the error of the error of the error of the error of the evaluation of the eval | or out. e physician eation perious destates, "Catates," The agia and control end agia and control end agia and control end agia and control end agia and control end agia and control end agia and control end agia and control end agia and control end agia and control end agia agia agia agia agia agia agia agi | | | | CROSS-REFERENCED TO THE APPROP | ERIATE | |
| The ph Do No a full c home t under t | ysician si t Resuscit code. Staf from 5/16/ | gned the POC/485 as a ate. The patient is really if have been going to the 414 till today (6/13/14) assion the patient was a | | | | | |

State Form Event ID: XOE711 Facility ID: 012349 If continuation sheet Page 109 of 111

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|------------------------|---|--|--|
| | | 157631 | A. BUILDING B. WING | | 06/13/2014 | |
| | PROVIDER OR SUPPLIER | | 1815 S | ADDRESS, CITY, STATE, ZIP CODE S PLATE STREET MO, 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 APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | |
| N000606 | Resuscitate State DNR order will primary physicial originated during stay, a new order use by the home 410 IAC 17-14-1(r Scope of Services Rule 14 Sec. 1(n) therapist in therapithe initial visit to the make a supervisor (30) days, either wis present or abseassess relationship whether goals are Based on clinical review and interview an | g the patient's hospital r must be obtained for health agency)." A registered nurse, or y only cases, shall make he patient's residence and ry visit at least every thirty when the home health aide nt, to observe the care, to ps, and to determine being met. I record and policy view, the agency failed to ered nurse completed a ref of the home health aide required by agency records reviewed of eived skilled and home ces longer than 14 days | N000606 | The DON and ADON will educe staff regarding aide supervision 484.36dB. The QI manager with audit 20% of new and current charts monthly for the next year to ensure supervisory visits ar made by RN In accordance withe regulations. The DON, AD and QI manager will be responsible for monitoring the corrective actions for compliar The deficiency will be corrected by July 13, 14. | on on on on on on on on on on on on on o | |

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PRINTED: 07/21/2014 FORM APPROVED OMB NO. 0938-0391

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157631 | (X2) MU A. BUIL B. WINC | DING | NSTRUCTION 00 | (X3) DATE : COMPL 06/13/ | ETED | |
|---|--|--|--|---------------------|---|--------------------------------|----------------------------|--|
| 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 | |
| | number 2.49 state client is receiving home health care make a supervise client's residence. 2. Clinical reconsorder written by 5/15/14 stated, "Services, skilled other week] HH, health aide one to days a week for [physical therapy Home health aide aides services were mployee Q, HH, May 15 through evidenced the physical therapy completed the extreatments were and 29 and June. The clinical the physical there conducted a supervery 14 days. 3. On June 12, 2 employee A individence in the physical conducted a supervery 14 days. | IA, 4 hours a day from 31, 2014. The record hysical therapist valuation on 5/23/14 and provided on May 23, 27, | | | | | | |

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