

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157631	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2014
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NAME OF PROVIDER OR SUPPLIER COMFORT HOME HEALTH LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1815 S PLATE STREET KOKOMO, IN 46902
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N000000	<p>This was the second revisit for an state re-licensure home health survey conducted on June 11, 12, and 13, 2014, with the first revisit July 25, 2014.</p> <p>Survey date: September 8, 2014</p> <p>Facility #: 012349</p> <p>Medicaid #: 201004280</p> <p>Surveyor: Bridget Boston, RN, PHNS</p> <p>During this survey it was determined eight deficiencies were corrected, one was recited, and two new deficiencies were cited.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN September 10, 2014</p>	N000000	The governing body of the agency has met to discuss the results of the survey and takes the regulatory compliance very seriously. This plan of correction serves as the agencies credible allegation of compliance with the Indiana state licensure rules.	
N000494	<p>410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and</p>			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see 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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	<p>promote the exercise of these rights and shall do the following:</p> <p>(1) Provide the patient with a written notice of the patient's right:</p> <p>(A) in advance of furnishing care to the patient; or</p> <p>(B) during the initial evaluation visit before the initiation of treatment.</p> <p>(2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on home visit observation, policy review, and interview, the agency failed to ensure all patients received written notice of the patient's rights in advance of care and the initiation of treatment for 1 of 1 observation of the initial assessment (patient 18), with the potential to affect all patients of the agency admitted for services by employee N.</p> <p>The findings include:</p> <p>1. On September 8, 2014, at 12:30 PM, employee N was observed during the initial home visit of patient 18. Employee F was also present during the visit. The patient's private caregiver indicated, during introductions, the patient was hard of hearing. Upon entering the home, employee N requested the patient to sign the agency document titled "Admission Service Agreement." The employee indicated that by signing the form the patient was consenting for the nurse to provide care. The one page,</p>	N000494	N494: All clinicians will be inserviced on patient rights and that the written notice of patient rights is reviewed with the patient in advance of furnishing care to the patient. A process will be developed by the Director of Nursing to detail the policy on patient rights. Monthly random supervisory visits will be performed on admission visits to ensure compliance with informing the patient of their rights. The DON and ADON will be responsible for ensuring ongoing compliance with N494 and making the supervisory visits. This deficiency will be corrected by September 26, 2014.	09/26/2014

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	<p>one sided document included the following areas: "Consent for Care / Service, Authorization for Release of Information, Liability for Payment, Assignment of Benefits, Consolidated Billing, Acknowledgement of Information, and above the patient's signature the form stated, "This Admission Agreement is applicable to this admission to the organization. I understand what I have read and what was explained to me and agree to the terms and conditions as above. Additionally, I understand that either party may terminate this agreement for any reason and / or at any time." To the left of the patient signature was an area reserved for staff signature, identified as "Admitting Clinician."</p> <p>A. Employee N then began asking the patient questions related to the patient's environment, ability to complete activities of daily living, and completed an assessment which included vital signs, assessment of skin, ability to transfer, mobility and safety concerns. Employee N provided information and education to the patient regarding the patient's anticoagulation therapy, safety issues identified, and fall precautions. At 2: 05 PM, employee N introduced the home health agency home folder and began to go through the folder and reviewed with</p>			

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	<p>the patient how one could contact the agency, office hours, and on-call. She then indicated to the patient she would not be going through the whole booklet but only "the highlights." She informed the patient of the individual that owned the agency, how and who to contact if the patient had issues, any concerns or complaints with any staff. She informed the patient there was information on Advance Directives in the folder, reviewed safety concerns that were identified in the home, the hotline phone number for the Indiana State Department Health, and informed the patient they had "healthcare choices." Then employee N presented the same document that was presented upon entrance to the patient's home, "Admission Service Agreement" and asked the patient to sign the second area reserved for the patient on the bottom of the form which stated above the signature line "Acknowledgement of receipt of Notice of Privacy Practices." The patient responded that the form was previously signed. Employee N informed the patient that by signing the form you have received and understand the information. The patient looked to the caregiver then signed the document. Employee N then informed the patient that services from the agency will be for two months. The patient responded with a facial expression questioning and said,</p>						

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	<p>" Two months?" Employee responded "We will be nice."</p> <p>B. Employee N failed to review and inform the patient of all their rights as a patient of a home health agency and failed to clarify and explain why services may extend for two months when the patient questioned the two month length of services, and failed to develop goals with the patient.</p> <p>C. At 2:20 PM, following conclusion of the home visit, employee N indicated she completed the home visit in the same style and process as normally conducted. She indicated that she does not provide the patient home folder and review with the patient before providing care because she has not determined if the patient is appropriate for home care until the comprehensive assessment in completed.</p> <p>2. On 9/8/14 at 4 PM, employee F indicated the preferred process was to explain the patient rights to the patient before care was provided.</p> <p>3. On 9/8/14 at 8 PM, employee F indicated the facility did not have a policy which directed the staff to review the patient rights with the patient before care was provided.</p>						

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N000522	<p>4. The undated facility policy titled "Client Bill of Rights Patient Rights and Responsibilities" number 1.41 stated, "The patient has the right: 1. To be fully informed and knowledgeable of all rights and responsibilities before providing pre-planned care and to understand that these rights can be exercised at any time."</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on policy and clinical record review and interview, the agency failed to ensure the skilled services were provided as ordered in 1 of 3 clinical records reviewed that were on service for a minimum of five days. (21)</p> <p>The findings included:</p> <p>1. The undated policy titled "Physician's Plan Of Treatment" number 2.18 stated, "A physician authorizes a plan of treatment prepared by the agency. Admission orders will be obtained prior to evaluation and treatment of the patient. ... Verbal orders may be accepted by</p>	N000522	N522: The agency will ensure skilled services are performed/provided as ordered by the physician. Any changes to the physician's plan of treatment will be faxed/sent to the MD for review as required by regulation. When a skilled service is unable to make a scheduled visit to provide services as ordered, a missed visit form will be completed. The Missed Visit form will be completed to reflect that the MD was notified of the change in frequency, the discipline that was missed, the reason the visit was missed, and that the opportunity to schedule another visit/staff was attempted. The patient will be offered another visit at the time the	09/26/2014

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	<p>professional nursing staff from a physician or staff nurse. They must be signed and dated within thirty (30) days. Verbal orders are to be recorded in the patient's clinical record by the professional receiving them. ... A physician's plan of care ... must include: The type and frequency of services needed, medications, specific orders for frequency or visits. ... Any changes to the physician's plan of treatment shall be reviewed by the attending physician."</p> <p>2. Clinical record 21, start of care 8/5/14, evidenced a plan of care with orders for physical therapy (PT) once a week for the first week of the certification period and twice a week for the following four weeks.</p> <p>A. The record evidenced that, during week four of the certification period, a PT visit was conducted on 8/26/14 and the last PT visit was conducted on 9/3/14, week five and the patient was discharged. A missed visit note indicated a missed visit occurred on 8/28/14 due to the family or patient [not specific] declined alternate visits of other staff. The documentation is not specific as to the options offered to the patient and declined. The form was stamped "Faxed" and written on the form was the date 9/3/14. At the bottom of the form,</p>		<p>clinician becomes aware of the missed visit. This form will be faxed to the MD to notify them of the missed visit and reason for the missed visit as well as the change in frequency that the missed visit occurs. 100% of missed visit forms will be audited by DON or ADON for completeness and notification to the MD. The DON will be responsible for ensuring ongoing compliance with N522. The effective date of this compliance is September 26, 2014.</p>				

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N000565	<p>hand written, was the change of frequency which occurred during the previous week. The form was not signed by the author. The record failed to evidence the physician was notified of a change in the frequency, prior to the missed visit, and a written physician order to change the frequency to one visit during week 4 of the certification period.</p> <p>B. The visit note dated 8/26/14 failed to evidence the therapist proposed a time and date for the next PT visit.</p> <p>3. On 9/8/14 at 7:35 PM, employee F indicated there was no other documentation and there was not a requirement to write a physician order because the notification was on the document faxed to the attending on 9/3/14.</p> <p>410 IAC 17-14-1(c)(4) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (4) help develop the plan of care (revising as necessary); Based on clinical record review and interview, the agency failed to ensure the speech language therapist (SLT)</p>	N000565	N565: The agency will ensure that therapies evaluate patients in a timely manner for the development of the patient's plan	09/26/2014			

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	<p>evaluated the patient timely for the development of the patient's plan of care in 1 of 1 clinical record reviewed with orders for a SLT. (Patient 20)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record 20 evidenced employee C completed the comprehensive assessment on 8/27/14 and identified the need for a SLT. Employee C obtained a physician order for speech therapy to evaluate the patient, dated 8/27/14. The record evidenced the SLT conducted their initial evaluation on 9/3/14 and obtained orders to provide ST three times for one week and then twice a week for the following five weeks for cognitive linguistic intervention. 2. On 9/8/14 at 5:15 PM, the administrator indicated the ST evaluation was late due to the holiday weekend. 3. At 5:30 PM, employee F indicated the agency goal was for therapy to evaluate by week two of the certification period. 		<p>of care. The goal is that therapies will assess the patient within the 5 day timeframe from date of admission. When it becomes evident that the therapy evaluation cannot be done within the 5 day window, the therapist will write a clinical addendum/communication note that will detail the delay in the evaluation by the therapist (Acceptable reasons for delay may include: pt request, holiday, family wants to be present, weather). This clinical addendum/communication note will be faxed to the MD to notify MD of delay in evaluation and reason delay is occurring. This clinical addendum/communication note will then become part of the permanent patient record. DON will inservice therapists on completing a clinical addendum/communication note when they are not able to evaluate a patient within the 5 day window. 100% review of therapy certification documentation will be performed by the DON/ADON to ensure ongoing compliance with N565. The effective date of this compliance is September 26, 2014.</p>		