STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOGETHER HOMECARE	555 E COUNTY LINE ROAD SUITE 105, GREENWOOD, IN, 46143

(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
N0000	Initial Comments This visit was for a follow-up to a State Relicensure survey of a Medicaid Home Health Provider that was originally conducted on 3/17/22. Survey Dates: 5/2/2022, 5/4/2022, 5/5/2022 and 5/6/2022 QR by Area 3 completed on 5-24-2022	N0000	POC accepted on 8-22-2022 Deborah Franco, RN	2022-06-06
G0000	INITIAL COMMENTS This visit was for a Federal Post Condition revisit and a follow-up to a State Relicensure survey of a Medicaid Home Health Provider that was conducted on 3/17/22. Survey Dates: 5/2/2022, 5/4/2022, 5/5/2022 and 5/6/2022 During this survey, 3 Condition level deficiencies were corrected; no Condition level deficiencies were recited; 20 standard level	G0000	Together Homecare(“Together”) submits the following Plan of Correction as required by State andFederal law. Together’s submission of this Plan of Correction should notbe taken as an agreement with or admission of any of the findings contained therein.Together	2022-06-06

	deficiencies were corrected; and 3 standard level deficiencies were recited. Based on the Condition-level deficiencies during the 3/17/2022 survey, your HHA was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 3/17/2022. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency continues to be precluded from operating or being the site of a home health aide training, skills competency, and/or competency evaluation programs for a period of two years beginning 3/17/2022 and continuing through 3/16/2022. QR by Area 3 on 5-27-2022 The deficiencies cited in this survey are reflected in findings cited pursuant to 410 IAC 17. QR by Area 3 completed on 5-24-2022		hereby expressly reserves the right to challenge the factual findings,legal conclusions, and allegations contained in the underlying reports. Compliance has been and will be achieved nolater than the last completion date identified in the Plan of Correction. Together desires this Plan of Correction to be considered our CreditableAllegation of Compliance	
N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.	N0464	In acknowledgement of the IDOH memo, waiving the state TBrequirements when a national standard is adopted, the Governing Body approvedan updated Health Screening policy in January 2021, in accordance with theCenters for Disease Control national standards for TB testing for healthcareworkers. The Agency’s policy Occupational Exposure to Tuberculosis D257 has beenupdated to align with CDC national standards. A new Governing Body meeting	2022-06-06

	(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on record review and interview, the agency failed to adopt a written national standard of practice to control the risk of		washeld to approve this policy modification and to formally acknowledge the formaladoption of the CDC national standard in 2021, which was reflected in the HealthScreening policy. All staff members have participated in an in-serviceregarding the Agency's TB policy and CDC national standards. All employee filesare 100% compliant with Agency policies. All incoming staff members responsible for onboarding newemployees will continue to be educated on the Agency's policies regarding TBscreening and testing. The Governing Body will continue to review policies forany state or federal changes, and at least annually, to ensure all Agencypolicies continue to align with state and federal regulations. The Administrator or designee will audit 100% of personnelfiles for 30 days to ensure continued compliance with Agency policies for TBtesting and screening. After 30 days, the Agency will include a review of TBtesting and screening during the 10% quarterly personnel file audit, as part ofthe Agency's	

	transmission of tuberculosis (TB) and failed to obtain and retain documentation of direct contact employees' tuberculosis evaluations and/or for an annual risk assessment screening for in 6 out of 7 employee records reviewed (Employees E, G, H, I, J, and K) The findings included: 1. A review of the Indiana Administrative Code 410 IAC 17-21-1(i)-6- revealed, The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months." A review of the policy for exemption by the Indiana State Department of Health revealed, To be exempt from 410 IAC 17-21-1(i), the agency must formally adopt a nationally recognized standard; implement and follow the standard as written & 2. A review of an undated agency policy titled, Occupational Exposure to Tuberculosis Prevention Plan D-257 , revealed, &The agency will perform an annual TB assessment screening of agency staff & 3. A review of the personnel record of Employee E, RN (registered nurse), revealed the date of the most recent tuberculosis (TB) test or screen was 11/11/19. 4. A review of the personnel record of Employee G, RN, revealed the date of the most recent TB test or screen was 08/24/20. 5. A review of the personnel record of Employee H, RN, revealed the date of the most recent TB test or screen was 10/19/20.		QAPI program to ensure continued compliance. The Administrator and Director of Clinical Services areresponsible for monitoring these corrective actions to ensure the deficiency iscorrected and will not recur. Completed 6/6/22.	

	6. A review of the personnel record of Employee I, home health aide (HHA), revealed the date of the most recent TB test or screen was 09/09/19. 7. A review of the personnel record of Employee J, Licensed Practical Nurse (LPN), revealed the date of the most recent TB test or screen was 02/13/19. 8. A review of the personnel record of Employee K, HHA, revealed the date of the most recent TB test or screen was 5/14/19. 9. On 5/5/22 at 2:15 PM, Employee A, the Administrator, when queried about the above personnel files of current employees without documentation of any type of assessment within the past year for the risk of TB transmission, confirmed annual risk assessments were not documented and the information in the employee files was the current information to date for the employees.			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the agency failed to ensure all medication prescribed and currently in use had been reviewed and incorporated into the patient	G0536	The medications for the patient identified in the surveyhave been confirmed with the ordering physician and incorporated into thepatient's medication list and electronic MAR. All patient medication profileshave been reviewed and are current. All employees have been re-educated on the requirement toupdate the medication list as soon as a medication change occurs. All nurseshave also been	2022-06-06

	record for 1 (Patient 5) of clinical records reviewed. Findings include: 1. A review of the clinical record for Patient 5, a pediatric patient, revealed a start of care date of 2/20/17, with a certification period of 3/16/22 to 5/14/22, and diagnoses that included, but were not limited to, Lowes Syndrome (the oculocerebrorenal syndrome of Lowe, or OCRL is a multisystem disorder characterized by anomalies affecting the eye, the nervous system, and the kidney) and epilepsy (a brain disorder that causes seizures), gastrostomy tube ('g-tube', a tube, surgically placed through the abdomen, to help deliver medications, liquids, and liquid food directly into the stomach) had skilled nursing ordered for 5 times per week for 9 weeks, for medication administration and enteral feeding administration via g-tube. A review of an agency document titled 'Nursing Visit (Field) - Together RN,' dated 5/2/22, which was documented as between 7:00 AM to 3:00 PM, and completed by Nurse D, a registered nurse, evidenced an elevated tympanic membrane (eardrum) temperature reading of 99.9 degrees Fahrenheit. The document failed to evidence any further assessment was performed based on elevated temperature and the record also failed to evidence documentation of notification of a change in the patient's condition to the physician or to other members of the care team, director of clinical supervision, or to the parents. A review of an agency document titled 'Nursing Visit (Field) - Together RN,' also dated 5/2/22, which was documented as between 3:00 PM to 5:00 PM, was completed by Nurse D and evidenced an elevated tympanic membrane (eardrum) temperature reading of 99.6 degrees Fahrenheit. The nurse's note failed to evidence any further assessment, communication, or action was taken.		re-educated on the need to clarify information with the orderingprescriber or pharmacy if the patient or representative does not have theneeded information. All incoming employees will receive this education duringthe orientation and training process. The Director of Clinical Services or designated RN willreview 100% of medication profiles for 30 days to ensure continued compliancewith this requirement. After 30 days, medication profiles will continue to bereviewed during the 10% quarterly clinical record audit as part of the Agency'sQAPI program. The Administrator and Director of Clinical Services areresponsible for monitoring these corrective actions to ensure the deficiency iscorrected and will not recur.	

Further review of the remainder of the clinical record failed to evidence documented entries in the client loggings/communication notes related to the elevated temperature finding from the 5/2/22 nursing visit notes.

On 5/6/22 at 10:15 AM, upon further review of the clinical record for Patient 5, the record failed to evidence nursing visit documentation updates to medication profile, or nursing communication notes dated after 5/2/22.

On 5/6/22 at 11:22 AM, a document was created for the clinical record titled 'Revision to Plan of Care' by the clinical manager which stated, "Medication changes: Added: Augmentin ES-600 Oral Suspension Reconstituted 600-42.9 MG/5ML - G-tube - 5.5mL - 05/03/2022 - 05/13/2022 - Given with breakfast and evening feedings - Twice a Day

Added: Polytrim Opthalmic Solution 10000-0.1 UNIT/ML-% - Opthalmic - 1 drop- 05/03/2022 - 05/03/2022 - 05/10/2022 - plACe 1 drop in both eyes every 6 hours - Every 6 Hrs..."

2. In an interview on 5/4/22 at 1:28 PM, Nurse B of Dr. C's office stated Patient 5 had visited the doctor's office on 5/2/22, and was diagnosed with an ear infection. Nurse B could not give further information but indicated would have the doctor's nurse call back when the office reopened.

In an interview on 5/6/22 at 10:13 AM, Nurse D of Dr. C's office confirmed Patient 5 was diagnosed with an ear infection and bacterial conjunctivitis at a visit on 5/2/22. Nurse D also stated Patient 5 was prescribed Amoxicillin - Clavulanate (Amoxicillin ES-600) 600-42.9 mg/ 5 mL oral suspension, take 5.5 mL (600mg) 'by mouth' (Nurse D recognized the error and will clarify with provider to be given by G-tube) with breakfast and with evening meal for 10 days and was also prescribed Polymixin B Sulf-trimethoprim (POLYTRIM) 10,000 unit -

	1mg/mL ophthalmic solution, place one drop into both eyes every 6 (six) hours for 7 days. The prescriptions had been written by Dr. C on 5/2/22 at 10:12 AM. In an interview on 5/6/22 at 10:20 AM, with the clinical manager, when queried as to whether she was aware Patient 5 had had an infection and had been ordered antibiotics, the clinical manager stated she was aware, because she had been to the home on 5/3/22. At that time the clinical manager visited with Person A (the patient's primary caregiver) while another family member was out getting the medication prescription filled at the pharmacy. Person A was unable to tell the clinical manager the names of the medications which had been prescribed. The clinical manager was unable to answer if Nurse D had been administering the medication after the family had obtained the 2 prescription medications. 410 IAC 17-4-1(a)(1)(B)			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on record review and observation, the agency failed to ensure clinicians followed accepted standards of practice, including the use of standard precautions, to prevent transmission of infections and communicable diseases in 2 of	G0682	All Agency employees have been re-educated on infectioncontrol precautions, including proper handwashing and gloving practices. Allnurses have been re-educated on the requirement to wear gloves for all directcare tasks, including accessing a patient’s feeding tube. All employees haveconfirmed understanding of this re-education. All incoming employees will continue to receive thiseducation during the orientation and training	2022-06-06

	(Patients #1 and 3) Findings include: 1. A review of an agency s policy titled, 'Handwashing/Hand Hygiene D-330,' dated 12/30/21, evidenced POLICY In an effort to reduce the risk for infection in patients and staff members thorough hand washing/hand antisepsis is required of all employees & PURPOSE to improve hand-hygiene practices & to reduce transmission of pathogenic microorganisms & c. When there is prolonged or intense contact with the patient (bathing the patient). d. Between tasks on the same patient &f. After removing gloves. g. After touching objects that are potentially contaminated & A review of an agency s policy titled, 'Standard Precautions for All Health Care Workers D-245,' dated 12/30/21 evidenced POLICY Together Home are employees will exercise standard precautions whenever in the direct care or contact with any patients & SPECIAL INSTRUCTIONS & Gloves should be changed after each patient contact. When gloves are removed, thorough hand washing is required & A review of an undated agency policy titled, Infection Prevention /Control B-403 , evidenced POLICY Agency will observe the recommended precautions for home care as identified by the Centers for Disease Control &PURPOSE To ensure employee and patient safety &SP[ECIAL INSTRUCTIONS &DISEASE-SPECIFIC STANDARD PRECAUTIONS-TIER TWO This approach provided isolation guidelines with new transmission categories &Types of care that may place patients at risk &Enteral tube feedings &" A review of an undated agency procedure titled, GASTROSTOMY TUBE CARE E-130 ,		process, prior to the provisionof patient care. The Director of Clinical Services or designated RN will continueto observe handwashing and gloving procedures during in-person patient visitsto ensure employees remain compliant with practicing proper infection control measures. The Administrator and Director of Clinical Services areresponsible for monitoring these corrective actions to ensure the deficiency iscorrected and will not recur.	

	Refer to the Hand Washing procedure. Don clean gloves & 2. A review of the clinical record of Patient #1, with the start of care date of 1/27/17, revealed a 'Home Health Certification and Plan of Care' , dated 1/27/21, for the certification period of 2/25/22 to 4/25/22, with diagnoses, but not limited to, Cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture) and Gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food) status. The patient was to receive skilled nursing services 3-5 days per week for personal hygiene, enteral feedings, medications, and transfers. At a home visit on 5/5/22 at 10 AM with Patient #1, a registered nurse (RN) G imitated the visit by demonstrating drawing the patient s medications up in syringes for a later time. RN G stated they had already given the patient their 9:30 am medications but could perform a small water flush via g-tube (gastrostomy tube). RN G prepared the items for the water flush. RN G, then performed hand hygiene, went to the patient, connected the tubing to the g-tube, and proceeded with the water flush. RB G returned to the kitchen and returned all the supplies to a basket on the counter. A review of an agency's document titled 'Position: Registered Nurse (JD-140), signed and dated by RN G on 4/3/20 evidenced "...7. Promotes personal safety and a safe environment...a. Demonstrates knowledge of safety/infection control practices by complying with established policies and procedures..." The RN failed to perform hand hygiene before drawing up the patient s medications, failed to don gloves before the gastrostomy procedure, and failed to perform hand hygiene upon completion of the gastrostomy procedure.			

3. A review of the clinical record of Patient #3, with the start of care date of 10/1/20, revealed a 'Home Health Certification and Plan of Care', for the certification period of3/25/22 to 5/23/22, with diagnoses, but not limited to, Deletion of a short arm of Chromosome 4 (causes the features of Wolf-Hirschhorn, including facial features like wide-set eyes, a distinct bump on the forehead, a broad nose, and low-set ears), and feeding difficulties. The patient was to receive skilled nursing services 3-5 days per week for assistance with bathing as needed and administer medications and g-tube feedings.

At a home visit on 5/4/22 at 2 PM with Patient #3, a registered nurse (RN) E stated they were going to perform a gastrostomy feeding (g-tube). RN E assisted patient 3 into the kitchen and seated at the table for the feeding. RN E performed hand hygiene, donned gloves, picked up ta tray that had already been set up for the tube feeding, and placed it on the table. RN E stated they were missing something, doffed their gloves, went to the pantry, opened the door, and went into the pantry looking through items, stating they might have to go upstairs for additional supplies. RN E came back into the kitchen, donned gloves, and proceeded to check patient #3 for residual feeding, within normal limits proceeded to administer the enteral feeding. After the enteral feeding was completed, RN E completed the feeding with a 60 ml (milliliter) water flush and doffed their gloves. RN E placed all supplies in the sink, started washing and rinsing all items, placing items in a drying rack, and covered with a dry towel when completed, stated that s what I do.

A review of an agency's document titled 'Position: Registered Nurse (JD-140), signed and dated by RN E on 11/6/19 evidenced "...7. Promotes personal safety and a safe environment...a. Demonstrates knowledge of safety/infection control practices by complying with established policies and procedures..."

	The RN failed to perform hand hygiene at appropriate intervals. 410 IAC 17-12-1(m)			
G0704	Responsibilities of skilled professionals 484.75(b) Standard: Responsibilities of skilled professionals. Skilled professionals must assume responsibility for, but not be restricted to, the following: Based on record review and interview, the agency failed to ensure the registered nurse's visit note was complete and the documentation accurately reflected the patient's condition in 1 (Patient 5) of 7 clinical records reviewed. 1. Review of an agency document titled 'Skilled Nursing Services C-200,' dated 12/30/21, evidenced the policy stated, "POLICY Skilled Nursing services will be provided by a registered nurse...and in accordance with a medically approved Plan of Care (physician's orders) &PURPOSE To abide by state and federal guidelines and offer guidelines to the agency staff, physicians, and community for the appropriate utilization of professionally skilled nursing services...SPECIAL INSTRUCTIONS 1. The registered nurse: & b. Regularly reevaluates the patient's needs, and coordinates the necessary services...d. Provides services requiring specialized nursing skill and Initiates appropriate preventative and rehabilitative nursing procedures. e. Informs the physician and other personnel of changes	G0704	All employees have been re-educated on the requirement todocument changes in patient condition, including updates in diagnoses,medications, or other elements of the plan of care, within the patient’s visitnote when care is provided. All nurses have been re-educated on the importanceof monitoring vital sign trends and reporting assessed changes in trends,including vital signs falling outside of ordered call parameters, to theordering provider. All employees have been re-educated on the requirement toreport these changes in condition to the Agency. All incoming employees will continue to receive thiseducation during the orientation and training process.	2022-06-06

	Prepares clinical notes. Documents changes in patient condition and action taken, including informing the physician and other appropriate medical personnel, update care plans, obtain physician orders, and communicates verbally and in writing to members of the team....4. The nurse will demonstrate competency in providing procedures such as: & c. Documenting and implementing physician orders....5. Specialized services such as Pediatric Nursing ... and other services as appropriate." 2. Review of an agency document titled 'Clinical Documentation C-680,' dated 12/30/21, evidenced the policy stated, "POLICY Together Homecare will document each direct contact with the patient. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for the patient's care. PURPOSE To ensure that there is an accurate record of the services provided, patient response and ongoing need for care. To document conformance to the Plan of Care ... SPECIAL INSTRUCTIONS 1. All skilled services provided by nursing...will be documented in the clinical record ... 3. Additional information that is pertinent to the patient's care or condition may be documented on a progress note or clinical documentation note...4. Telephone or other communication with patients, physicians, families or other members of the health care team will be documented in client loggings or other coordination form established by the agency. 5. Documentation of services provided according to the Plan of Care will be completed the day service is rendered and incorporated into the clinical record within 14 days after the care has been provided." A review of an agency document titled 'Services Provided C-100' dated 12/30/21, evidenced the document stated, "The qualifications and competence of the individual(s) providing service are appropriate to patient needs and the required services and comply with applicable laws and regulations ... "		The Director of Clinical Services or designated RN willreview 100% of nursing visit notes for patients with condition changes weeklyfor 4 weeks to ensure continued compliance with this requirement. After 4 weeks,nursing visit notes will continue to be reviewed during the 10% quarterlyclinical record audit as part of the Agency’s QAPI program to ensure ongoingcompliance. The Administrator and Director of Clinical Services areresponsible for monitoring these corrective actions to ensure the deficiency iscorrected and will not recur.	

3. A review of the clinical record for Patient 5, a pediatric patient age 5 years, revealed a start of care date of 2/20/17, with a certification period of 3/16/22 to 5/14/22, and diagnoses that included, but were not limited to, Lowes Syndrome (the oculocerebrorenal syndrome of Lowe, or OCRL is a multisystem disorder characterized by anomalies affecting the eye, the nervous system, and the kidney) and epilepsy (a brain disorder that causes seizures), gastrostomy tube ('g-tube', a tube, surgically placed through the abdomen, to help deliver medications, liquids, and liquid food directly into the stomach) had skilled nursing ordered for 5 times per week for 9 weeks, for medication administration and enteral feeding administration via g-tube.

A review of agency documents titled 'Nursing Note' evidenced the tympanic membrane (eardrum) temperature readings (in degrees Fahrenheit) for the following dates: 4/1/22 - 97.6, 4/4/22 - 98.1, 4/5/22 - 97.1, 4/6/22 - 96.9, 4/7/22 - 97.3, 4/8/22 - 96.8, 4/9/22 - 96.9, 4/11/22 - 97.1, 4/12/22- 96.8, 4/13/22 - 96.8, 4/14/22 - 97.1, 4/15/22 - 96.8, 4/16/22 - 96.9, 4/18/22 - 98.3, 4/19/22 - 97.3, 4/25/22 - 98.1, 4/26/22 - 98.1, 4/27/22 - 97.2, 4/28/22 - 97.3, and 4/29/22 - 97.3. (Patient 5's average for the above dates was 97.6 degrees Fahrenheit.) The average temperature is generally recognized to be 98.6 degrees Fahrenheit, with a range of 97 to 99 degrees.

A review of an agency document titled 'Nursing Visit (Field) - Together RN,' dated 5/2/22, which was documented as between 7:00 AM to 3:00 PM, and completed by Nurse D, a registered nurse, evidenced a temperature reading of 99.9 degrees Fahrenheit. The document failed to evidence any further assessment was performed based on elevated temperature and the record also failed to evidence documentation of notification of a change in the patient's condition to the physician or to other members of the care team, director of clinical supervision, or to the parents.

A review of an agency document titled 'Nursing Visit (Field) - Together RN,' also dated 5/2/22, which was documented as between 3:00 PM to 5:00 PM, was completed by Nurse D and evidenced a tympanic membrane (eardrum) temperature reading of 99.6 degrees Fahrenheit. The nurse's note failed to evidence any further assessment, communication, or action was taken.

Further review of the remainder of the clinical record failed to evidence documented entries in the client loggings/communication notes related to the elevated temperature finding from the 5/2/22 nursing visit notes.

On 5/6/22 at 10:15 AM, upon further review of the clinical record for Patient 5, the record failed to evidence nursing visit documentation updates to medication profile, or nursing communication notes dated after 5/2/22.

4. In an interview on 5/4/22 at 1:28 PM, Nurse B of Dr. C's office stated Patient 5 had visited the doctor's office on 5/2/22, and was diagnosed with an ear infection. Nurse B could not give further information but indicated would have the doctor's nurse call back when the office reopened.

5. In an interview on 5/6/22 at 10:13 AM, Nurse D of Dr. C's office confirmed Patient 5 was diagnosed with an ear infection and bacterial conjunctivitis at a visit on 5/2/22. Nurse D also stated Patient 5 was prescribed Amoxicillin - Clavulanate (Amoxicillin ES-600) 600-42.9 mg/ 5 mL oral suspension, take 5.5 mL (600mg) 'by mouth' (Nurse D recognized the error and will clarify with provider to be given by G-tube) with breakfast and with evening meal for 10 days and was also prescribed Polymixin B Sulf-trimethoprim (POLYTRIM) 10,000 unit - 1mg/mL ophthalmic solution, place one drop into both eyes every 6 (six) hours for 7 days. The prescriptions had been written by Dr. C on 5/2/22 at 10:12 AM.

In an interview on 5/6/22 at 10:20 AM, with the clinical manager, when queried as to whether she was aware Patient 5 had had an infection and had been ordered antibiotics, the clinical manager stated she was aware, because she had been to the home on 5/3/22. At that time the clinical manager visited with Person A (the patient's primary caregiver) while another family member was out getting the medication prescription filled at the pharmacy. Person A was unable to tell the clinical manager the names of the medications which had been prescribed. The clinical manager was unable to answer if Nurse D had been administering the medication after the family had obtained the 2 prescription medications.

In an interview on 5/6/22 at 1:15 PM, when queried about Nurse D's notes from 5/2/22, and what the agency's expectation would be, the clinical manager indicated she would have expected the nurse to have filled out section of the note titled 'Clinical Documentation Together Communication visit note' which included four sections within, titled 'Communication with Physicians', 'Change in Orders', 'Communicated with Agency or Other Care', and 'Provider from Plan of Care' and document follow-up actions in relation to Patient 5's elevated temperature.

410 IAC 17-14-1(E)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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