STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K141	A. BUILDING 00 B. WING	09/18/2020

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

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G 0000 Bldg. 00		G 0000		

This visit was for post condition revisit survey of a Medicaid only home health agency, completed on 5-15-2020.

Survey Dates: 9-2, 9-3, 9-4, 9-7, 9-8, 9-9, 9-10, 9-11, 9-16, 9-17, and 9-18-2020

Facility #: 013867

CCN: 15K141

Facility Census: 160 combined for the Greenwood parent and the Columbus branch

Records reviewed without home visits: 5
Home visits with record review: 1
Total records reviewed: 6

During this post condition revisit survey, the Condition of Participation Infection Control, 42 CFR 484.70, and 2 standard level deficiencies were corrected. This deficiency reflects State Findings cited in accordance with 410 IAC 17.

Based on the Condition-level deficiencies during the May 15, 2020 survey, your HHA was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on September 2, 2020. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training and/or competency evaluation programs for the two years beginning May 15, 2020 and continuing through May 14, 2022.

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Quality Review Completed on 10/09/2020 by Area 3			
G 0572 Bldg. 00	484.60(a)(1) Plan of care Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure the plan of care visit hours for home health aide visits were individualized and based on meeting the patients identified needs for 2 (Patients #1 and 6) of 4 patients who received home health aide only services; failed to ensure visits were provided as ordered in the plan of care for 1 (Patient #1) of 4 patients who received home health aide only services; failed to include an established minimum number of baths/showers per week for 1 (Patient #1) of 4 patients who received home health aide only services; and failed to ensure the nurse visit hours on the plan of care were individualized and based on the patient's needs for (Patient #4) of 2 patients who received skilled care, in a sample of 6 patients whose clinical records were reviewed. The findings included:	G 0572	G 572 All internal clinicians have been re-educated on ensuring that each patient's frequency and duration is individualized. All clinical records have been reviewed to validate that the visit hours established on the plan of care for nurses and home health aides are individualized, based on meeting the identified needs of the patient. Any deviation from the ordered frequency and duration will continue to be documented with a missed visit note or supplemental order and communicated to the Physician. The Director of Clinical Services or RN designee will audit 100% of outgoing plans of care for 30 days to ensure that each patient's	10/21/2020

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	Review of a policy, "Plan of Care," last reviewed/revised 8-21-2019, evidenced the policy stated, "Home care services are furnished under the supervision and direction of the patient's physician. The plan of care is based on a comprehensive assessment and information provided by the patient/family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days ... The Plan of Care shall be completed in full to include: ... Frequency and duration of visits to me made ... All medications and treatments ... Patient-specific interventions and education; measurable outcomes and goals ... " Review of the clinical record for patient #1, evidenced a start of care of 7-5-19, and contained a plan of care for the certification period of 7-5 to 9-2-2019, with orders for home health aide (HHA) "Medicaid State Frequency and Duration: 1 visit/day X 6-7 days/week for 9 weeks ... Medicaid PA [sic prior authorization] Program Hours: The patient has chosen to schedule PA hours as follows: 1-5 hours/day X 3-5 days/week, 2-6 hours a day X 1-2 days/week, 0.5- 4 hours/day X 1-3 days/week ... Medicaid Waiver Program Hours: The patient has chosen to schedule Waiver hours as follows: 3-7 hours/day X 3-5 days/week, 2-6 hours/day X 1-2 days/week, 4-8 hours/day X 1-3 days/week." The primary diagnosis was Multiple Myeloma. Functional limitations listed included "endurance." HHA prior authorization hour duties enumerated on the plan of care included: ... Bathing: Shower chair/bench to be used during bathing; assist with		nursing or home health aide hours remain compliant with the requirement. Once 100% compliance has been maintained for 30 days, the Director of Clinical Services or RN designee will continue to include evaluation of the frequency and duration and adherence to the ordered frequency and duration as part of the Agency's quarterly 10% clinical record audit to ensure continued compliance. All HHAs and CNAs have been re-educated regarding properly documenting the reason for not completing a task during a visit. All RN Clinical Supervisors have been re-educated on the care planning process for home health aide tasks, including the establishment of a minimum weekly bath/shower schedule for patients with baths/showers on their aide care plan. The issue was immediately corrected when all Agency aide care plans were immediately audited by the Director of Clinical Services to ensure the presence of a minimum weekly bathing threshold when applicable. All aide care plans are currently 100% compliant. In order to ensure a deficient practice does not occur, the Director of Clinical Services will audit 100% of new Aide Care Plans for 30 days to ensure 100% compliance with establishing a minimum number of	

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	Shower: PRN; Hygiene and Grooming: Assist with Shampoo PRN; Assist with Nail Care PRN; Assist with Dressing, PRN; Hair Care PRN; Peri Care PRN. The care task of shower/bath was ordered PRN [as needed] with no minimum shower/bath per week established. Review of patient #1 start of care comprehensive assessment, dated 7-5-2019, evidenced "Patient does not have a primary caregiver able to provide the hands on care he/she requires." Height of 5' 9" and weight of 270 pounds was documented. Patient #1 reported anticipating right foot surgery on 7-16-2019. For gastrointestinal "will experience bowel incontinence if he/she is very sick .... and wears incontinence products PRN [as needed.] Durable medical equipment included assistive devices of cane [rarely used,] walker Knee walker-used post-op, Manual wheelchair, used post-op, right foot brace, bilateral wrist/hand braces to used as needed, and shower chair/bench. Patient Independence was "Moderate Assist with ADLs [activities of daily living.] Review of the HHA care plan dated 7-5-2019, evidenced "Visit Frequency/Duration: 1 visit /day X 6-7 days/week." The documented schedule was "M [Monday]-Sat [Saturday] PA [prior authorization] = 9 AM to 12 P; W [Waiver] 12 PM to 5 PM ... Sun [Sunday] PA = 9 AM to 11 AM, W = 11 AM to 5 PM." The 30 assigned HHA tasks were consistent for every visit and did not vary at all by day of the week. Review of the home health aide visit notes, for PA and Waiver, evidenced documentation of shower/bath on 7-13-19, 8-5, 8-20, 8-21, 8-23, 8-24, 8-25, 8-28, 8-29, 8-30, and 8-31-2019. Patient #1 was documented to have received a shower/bath		baths/showers per week to be provided to the patient by the home health aide for patients with baths/showers on their care plan. After 30 days of 100% compliance, the Director or RN designee will include review of Aide Care Plans during the 10% quarterly record audit to ensure compliance is maintained. The Administrator and Director of Clinical Services are responsible for monitoring the corrective actions to ensure the deficiency will not recur.	

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	for 11 days out of a 60 day certification period. Review of the HHA visit notes failed to evidence documentation patient #1 had declined a shower or had taken shower without HHA assistance on the visits where no shower/bath had been documented as completed. Review of the HHA visit notes for Patient #1 failed to evidence the HHA had provided care visits on 8-19, 8-22, 8-26, 8-27, 9-1, and 9-2-2019. Review of HHA visit notes with the clinical director on 9-8-2020, at 1:15 P.M., evidenced the HHA visits were most often 3 hours for PA, and 4-5 hours for Waiver. The clinical director verified there were 4 weeks of the certification period for which zero shower/bath had been documented. When queried why the HHAs were in the home for patient #1, the clinical director said for hygiene and safety. When queried why no hygiene goal had been established individualized to include a minimum number of showers/baths per week, the clinical director stated believing "as needed" was adequate. When queried why the HHA visit orders had large ranges (PA of 1-5 hours/day ... 2-6 hours a day ... 0.5- 4 hours/day ... Waiver of 3-7 hours/day ... 2-6 hours/day ... 4-8 hours/day) the clinical manager stated it was for agency convenience in scheduling and to avoid having to contact physicians for any variances in care visits. When queried what the HHA could accomplish in a 0.5 hour visit, the clinical director indicated, "I don't know." When asked what justified the difference between a 1 hour and a 5 hour visit, a 2 hour and 6 hour visit, or a 0.5 hour visit and 4 hour visit, based on patient's #1 needs identified in the comprehensive assessment, the clinical director had no explanation. The clinical manager verified patient #1 did not have a qualified care giver in the home to assist with			

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	ADLs, and patient #1 had recent foot surgery which affected ambulation and mobility. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review. Review of the clinical record of patient #6 evidenced a start of care date of 8-17-2020, and contained a plan of care for the certification period of 8-17 to 10-15-2020, with orders for HHA care visits "Medicaid State Frequency and Duration: 1 visit/day X 6-7 days/week X 9 weeks; Medicaid PA Program Hours (HHA) The patient and his wife have chosen to schedule his PA [prior authorization] hours as follows: 0.5 to 4 hours/day X 1-3 days/week, and 5-9 hours/day X 4-6 days/week Medicaid Waiver Program Hours (HHA) The patient and his wife have chosen to schedule his Waiver hours as follows: 0.5 - 4.5 hours/day X 4-6 days/week." Patient #6 primary diagnosis was documented as Multiple Dystrophy, and evidenced wheelchair dependence and use of hoyer lift for transfers. HHA care duties ordered for PA were Assist patient to keep DME [durable medical equipment]/ Assistive Devices clean, and notify Clinical Supervisor if any items are in disrepair or require attention ... assist with wheelchair every visit, assist with ambulation/transfers every visit, Hoyer lift must be used for ALL patient transfers [use Hoyer lift or Stander] ... Shower chair/bench to be used during bathing, assist with shower ... (Tuesday and Friday) .. Change bed linens weekly and PRN [as needed,] Light Housekeeping every visit, assist with laundry weekly ... assist with dishes every visit, vacuum/sweep weekly and PRN, dust weekly and PRN ... Assist with Shampoo weekly and PRN, Assist with Dressing Every visit, Peri care Every visit ...			

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	Handling/Bringing meds [sic medications] to patient (No administering,) Verbal Medication Reminders Every visit ... Prepare/Serve Meals Every visit, Follow Aspiration Precautions, Assist with feeding, to include cut food into small bites PRN, Encourage Fluids Every visit ... Notify Clinical Supervisor if no BM in 3 days, Document last BM date PRN, Change brief/peri pad PRN, Assist to Commode Every Visit. Patient #6 was identified as a high risk for falls. The plan of care evidenced patient #6's wife worked outside home full time and was unable to provide necessary care during working hours. The plan of care failed to individualize the HHA visit hours to a minimum of greater than 0.5 hours for a visit, and failed to individualize the HHA care plan orders to ranges of visits which were rationally related to patient #6's need for assistance with ADLs [activities of daily living] when wife was at full time job. Review of the clinical record for patient #4, evidenced a start of care date of 5-12-2020, and contained a plan of care for the certification period of 5-12 to 7-10-2020, with orders for skilled nursing services "Medicaid State Frequency and Duration 1 visit/day X [sic for] 4-6 days/week for 9 weeks; Medicaid PA [prior authorization] Program Hours (Skilled Nursing) The patient's mother has chosen to schedule these hours as follows 6.5 - 10.5 hours/day X 4-6 days/week Medicaid Respite Hours (Skilled Nursing) The patient is authorized for Respite hours that the patient's mother will schedule on an as-needed basis." The plan of care evidenced diagnoses of Dravet Syndrome and comorbidities of developmental delay; cognitive delay; attention and concentration deficit; sleep related non-obstructive alveolar hypoventilation; other generalized epilepsy and epileptic syndromes; obesity; and gastrostomy [feeding tube] status. Review of the skilled			

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	nursing visit notes evidenced the nurse visits were consistently 8 to 10 hours to provide the care ordered on the plan of care. The nurse visit hour range from 6.5 to 10.5 hours per visit was too wide of a variation for care orders and was not individualized to meet the patient's needs. Review of the clinical record for patient #4, evidenced a start of care date of 5-12-2020, and contained a plan of care for the certification period of 7-11 to 9-08-2020, with orders for skilled nursing services "Medicaid State Frequency and Duration 1 visit/day X [sic for] 4-6 days/week for 9 weeks; Medicaid PA [prior authorization] Program Hours (Skilled Nursing) The patient's mother has chosen to schedule these hours as follows 6.5 - 10.5 hours/day X 4-6 days/week Medicaid Respite Hours (Skilled Nursing) The patient is authorized for Respite hours that the patient's mother will schedule on an as-needed basis." The plan of care evidenced diagnoses of Dravet Syndrome and comorbidities of developmental delay; cognitive delay; attention and concentration deficit; sleep related non-obstructive alveolar hypoventilation; other generalized epilepsy and epileptic syndromes; obesity; and gastrostomy [feeding tube] status. Review of the skilled nursing visit notes evidenced the nurse visits were consistently 8 to 10 hours to provide the care ordered on the plan of care. The nurse visit hour range from 6.5 to 10.5 hours per visit was too wide of a variation for care orders and was not individualized to meet the patient's needs. On 9-8-2020 at 2:01 P.M., the parent guardian of minor patient #4, when queried about plan of care hours for the skilled nurse, stated the nurses had to stay 8-10 hours to provide all the care patient #4 required. When queried whether guardian had chosen to schedule the skilled nursing care hours			

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	on a range of 6.5 to 10.5 hours, the guardian stated wanting all the hours patient #4 was allowed, to include respite care. The guardian of patient #4 stated the agency had never provided respite care hours due to lack of staffing. On 9-18-2020, at 4 P.M., the administrator and the director of clinical services (DOCS) verified the above findings, and stated the agency believed the ranges were proper because the attending physician had signed the plan of care orders. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS provided an email from June 17, 2019, from the director of IAHHC (Indiana Association for Home and Hospice Care) which stated a range of 1-7 days for care visits per week, was too much of a variable, and relied on this email to justify hours of care per visit ranges having 3-4 hours of variation as permissible, without justification for the range based on availability of a caregiver, or other pertinent factors. 410 IAC 17-13-1 (a)			