STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	l í	ILDING	nstruction 00	(X3) DATE SURVEY  COMPLETED  09/18/2020	
		15/141	B. WI			09/16/	2020
	ROVIDER OR SUPPLIER			555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 IWOOD, IN 46143	5	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
G 0000							
Bldg. 00	survey of a Medicai was a full extended the administrator was 1:45 P.M.  Complaint #: IN 00 related and unrelate  Survey Dates: 9-2, 9-16, 9-17, and 9-18  Facility #: 013867  CCN: 15K141  Facility Census: 16	9-3, 9-4, 9-7, 9-8, 9-9, 9-10, 9-11, 3-2020	G 00	000	Together Homecare ("Together") submits the following Plan of Correction a required by State and Federa law. Together's submission this Plan of Correction should not be taken as an agreemen with or admission of any of the findings contained therein. Together hereby expressly reserves the right to challeng the factual findings, legal conclusions, and allegations contained in the underlying reports.  Compliance has been and wi be achieved no later than the last completion date identifie	I of d t he	
	#6 was a limited reverse Record only)  Home visits:  An Immediate Jeopard administrator and cloon Friday, 9-11-202 Jeopardy began on Idocumented, when a employee D, failed assessment, and the a complaint, and continuestigation, as requisabled minor paties.	ds Reviewed: 6 (Clinical Record view for content of Clinical  1  ardy was identified and the inical manager were notified 0, at 2:49 P.M. The Immediate Monday, 8-24-2020, time not an agency supervisory nurse, to perform a complete agency failed to document as induct a thorough juired by agency policy, into a cent's (#4) observed injury of courple bruise on the upper right			in the Plan of Correction. Together desires this Plan of Correction to be considered our Creditable Allegation of Compliance.		

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

(X6) DATE

TITLE

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZP5711 Facility ID: 013867 If continuation sheet Page 1 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15K141  A. BUILDING  00  B. WING			COMPL 09/18/	ETED		
	ROVIDER OR SUPPLIER	2	555 E C	DORESS, CITY, STATE, ZIP CODE OUNTY LINE ROAD SUITE 10 WOOD, IN 46143	5	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	perpetrated by an age failed to document to observed injury of thave been perpetrate (employee B), to in videos; failed to document resolution abuse by an unident may have been an afailed to implement Complaints," which establish a procedure to the appropriate provide a response Complaints regarding charges will be document as a compressons with a competency of the process and to the process and to the process and to the process and the process are process. The immediate jeon as well as the home patients who receives medical conditions, patients.  The immediate jeon 8-24-2020, was remainded to the process are process.	e parent to have been gency nurse (employee B); an adequate resolution to the unknown origin alleged to ed by agency nurse clude reviewing the available cument as a complaint or to in to the allegation of verbal diffied person off camera, who gency nurse. The facility its policy, "Patient/Family is stated," Purpose To re for channeling complaints erson for resolution, and to to the patient/family ing treatment, services, or umented on the grievance form rying the complaint/grievance toon as possible to the for to the management team tion and trending All plaint will be notified of the tigate the complaint, the result the date of completion "  to conduct a complete quired by policy, failure to plaint with a responsive the risk of abuse/neglect and atients, posed a likely risk of rment, or death, to patient #4 health agency's 22 other ed skilled care for chronic of a total of 160 agency  array which began on toved on 9-18-2020, at 4:15 P.M., seen based on the agency's 3rd				
	when the actions tal	acii bascu oii ilic agelicy s Jiu				

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

Event ID: ZP5711

Facility ID: 013867

If continuation sheet Page 2 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/18/2020
	PROVIDER OR SUPPLIE HER HOMECARE	R	555 E	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 1 NWOOD, IN 46143	05
(X4) ID PREFIX TAG	immediacy removaremoved the immediate jeopard  Based on the Condidentified during the health agency was survey pursuant to Social Security Act Together Homecar compliance with CCFR 484.50 Patient Planning, Coordinate CFR 484.65 Quality Improvement; and Administration of Therefore, and pur (iii) of the Act, you operating or being training and/or compliance of the coordinate of the coordin	ition-level deficiencies as 9-18-2020, survey, your home subject to a partial or extended section 1891(c)(2)(D) of the t, on 9-9-2020 at 1:45 P.M. e was found to be out of onditions of Participation 42 t Rights; 42 CFR 484.60 Care ation and Quality of Care; 42 y Assessment/ Performance	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
G 0406 Bldg. 00	Quality Review Co 484.50 Patient rights Condition of parti The patient and r the right to be info in a language and understands. The promote the exer  Based on record re	reflects State Findings cited in	G 0406	Per ISDH instruction, a response is not recommend for this tag due to the abse	

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 3 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION       X3) DATE SUR         A. BUILDING       00       COMPLETE         B. WING       09/18/202			PLETED
	PROVIDER OR SUPPLIE	R	555 E (	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE NWOOD, IN 46143	105	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	N RF	(X5)
PREFIX TAG	•	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERIOR)	PRIATE	COMPLETION DATE
	Condition of Partic CFR 484.50, by ha dignity by failure to resolution to a comprivacy, by a home recorded video conwithout consent, whome and patient's posted the recorded 428;) having failed from verbal abuse, review all video tall skilled nurse shift a actions to protect a abusive language; a misappropriated been returned to a pailed to document failed to document complaint of physican injury of unknowith extended hour chronic medical coagency failed to do responsive resoluting 484.)  The cumulative effects resulted in the ager provision of quality the Condition of Patient Rights.  An immediate jeopunder 42 CFR 484.8-24-2020, and was a some privacy in the condition of Patient Rights.	ving failed to respect a patient's of document an adequate uplaint of invasion of a patient's the health aide, when the HHA attent in the patient's home, hich showed the patient's family members, and then divideo on You Tube (See Goto ensure a patient was free by having failed to obtain and pes recorded in the home during at issue; having failed to take and having failed to document thandicap parking sticker had patient (See Goto 430;) having sients received all the care visits of care (See Goto 436;) having as a complaint, and having a responsive resolution to a call and verbal abuse, to include with origin, for a minor patient, as of skilled nursing care for anditions (See Goto 482;) and the recument complete and constopations to patient complaints (See Goto 484;) and the recument complete and constopation and the recument complete and constopation.		of any cited findings.		

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

P.M. The agency's 3rd immediate jeopardy

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 4 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15K141 B. WING 09/18/2020 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 555 E COUNTY LINE ROAD SUITE 105 TOGETHER HOMECARE GREENWOOD, IN 46143 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE removal of immediacy plan and actions were determined to have removed the immediacy component of the immediate jeopardy on 9-18-2020, at 4:15 P.M. G 0428 484.50(c)(1) Property and person treated with respect Bldg. 00 Have his or her property and person treated with respect; G 0428 G 428 10/21/2020 Based on record review and interview, the agency An Investigation Guidance form failed to respect a patient's dignity by having has been added to all complaint failed to document an adequate resolution to a forms to assist in a thorough complaint of invasion of privacy and stolen investigative process, including property (Patient #1), by home health aide (HHA), requesting copies of any video or employee A, when the HHA recorded video audio recordings from the content in patient #1's home showing patient #1's complainant. To further ensure home and patient #1's family members, and then that the Agency's investigative posted the recorded video on You Tube for 1 of 1 process is thorough and clear, the complaints of failure to respect a patient's dignity, Agency's Patient Complaint of a total of 55 complaints in the complaint log for Policy (C-381) has been updated the year 2019. to include more detailed instructions for components of the The findings included: investigation, and the complaint form has been updated as well. All Review of an undated start of care packet, with internal employees have been patients rights enumerated, "Rights and educated on the new complaint Responsibilities," evidenced, " ... Together policy, the revised complaint form, Homecare must protect the exercise of these rights and the Investigative Guidance and maintain documentation showing that they document. have complied with the following rights: ... 3. To Complaints will not be considered have your person and your property treated with resolved until the Administrator respect ... 5. To ... voice grievances regarding and Director of Clinical Services the treatment or care that is (or fails to be) have both agreed that the furnished, or regarding the lack of respect for you investigation is complete, and all or your property by anyone who is furnishing evidence is clearly documented. services of behalf of the agency and must not be The Administrator and Director of subjected to discrimination or reprisal for doing Clinical Services will audit 100% of so. The agency must investigate complaints made complaints for 60 days to ensure

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

regarding treatment or care that is (or fails to be)

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

they contain evidence of a

Page 5 of 84

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/18/2020
	PROVIDER OR SUPPLIEI HER HOMECARE	₹	555 E	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE NWOOD, IN 46143	105
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) BE COMPLETION DATE
	furnished, or regard patient or the patient furnishing services must document bot resolution of the concept of	ling the lack of respect for the nt's property by anyone on behalf of the HHA, and h the existence and the		thoroughly documented investigation process, as we clear resolution and documentation that the complainant was notified or resolution. Once Agency has maintained 100% complianted 60 days, Administrator and Director of Clinical Services audit 20% of complaints que to ensure compliance is maintained. The Administrator and Director monitoring the corrective actions to ensure the deficit corrected and will not recurrently actions.	rell as a  f the as as ace for s will arterly actor of asible e ency is

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 6 of 84

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIPLE ( A. BUILDING B. WING	OO OO	(X3) DATE SURVEY COMPLETED 09/18/2020
	ROVIDER OR SUPPLIER		555 E	r address, city, state, zip cod COUNTY LINE ROAD SUITE 10 ENWOOD, IN 46143	05
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE 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
G 0430 Bldg. 00	handicap parking st ensure the parking squeried whether the You Tube videos powere recorded in pathe exact nature and patient #1's privacy audio portion to det identifying patient i responded, "No." Twrong of employee handicap parking st asked for additional explanation, or doct and DOCS indicate present for review.  410 IAC 17-12-3 (bd. 410 IAC 17-12-3 (bd. 484.50(c)(2)) Be free from abus Be free from verbaphysical abuse, in source, neglect arproperty;  Based on record revialed to ensure 1 (Fd. 410 IAC 17-12-14).	icker, and the agency would ticker was returned. When administrator had viewed the osted by employee A, which tient #1's home, to determine a scope of the invasion of to include listening to the termine if it contained information, the administrator the administrator stated it was A to take patient #1's icker for any reason. When pertinent information, amentation, the administrator in the having nothing further to (2)(A)(2)(A)(4)(B)  The provided Hamiltonian and coluding injuries of unknown and misappropriation of the ward interview, the agency extract #4) of 1 patient with	G 0430	G430 Investigations into the alleged verbal abuse and alleged neg	lect
	was determined to be having failed to obte recorded in the horn issue; having failed agency patients from having failed to dochandicap parking stepatient for 1 (Patient	n of verbal abuse of patient #4, be free from verbal abuse, by ain and review all video tapes be during skilled nurse shift at to take actions to protect all abusive language; and ument a misappropriated becker had been returned to a t #1) of 1 patients who had th the agency in relation to		of patient #4 were re-opened the Agency obtained additional information for its internal investigative process during the survey, including the review of video and audio recordings. A complaint investigations related patient #1 have been completed and the resolution has been communicated to the patient's	he f sull ed to ed,

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 7 of 84

PRINTED: 12/01/2020

EPARTMEN ENTERS FO		RM APPROVED IB NO. 0938-039						
STATEME	NT OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	î í	ILDING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/18/2020		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	0.5		
TOGETH	HER HOMECARE		555 E COUNTY LINE ROAD SUITE 105 GREENWOOD, IN 46143					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG	+	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		of property, in a sample of 6			family. Since the survey, ther	е		
	patients whose clin	nical record was reviewed.			have been no additional			
					complaints or concerns from			
	The findings include	ded:			family. The complaint investig			
	1 5				into the missing parking stick			
		ndated start of care packet, with			was also re-opened to docum			
		merated, "Rights and			clearer resolution and follow-			
	_	evidenced, " Together otect the exercise of these rights			The patient has since obtained			
	_	mentation showing that they			new handicap parking permit			
		h the following rights: 3. To			verbalizes satisfaction with he			
		and your property treated with			new full-time aide. The origin complaint has been resolved			
		free from verbal, mental, sexual,			I			
	_	, including injuries of unknown			the patient denies any additional complaints. The patient's full-time			
		d misappropriation of property			aide has been educated that the			
	"	i misappropriation of property			parking pass belongs to the	uic		
	<b>"</b>				patient and must be returned	after		
	2. Review of the c	linical record for patient #4,			each shift. All Together Home			
		#4 was a minor child with			patients have been contacted			
	_	et Syndrome and comorbidities			ensure there were no outstar			
	_	delay; cognitive delay; attention			complaints, including concern	•		
		deficit; idiopathic sleep related			regarding verbal, physical, se			
		veolar hypoventilation; other			or mental abuse or neglect,	,		
		sy and epileptic syndromes not			misappropriation of property	or		
		t status epilepticus; obesity,			injuries of unknown origin. No			
	unspecified; and ga	astrostomy [tube] status.			additional concerns regarding	g new		
					or previously reported or			
	Review of the plan	of care for the certification			unreported abuse			
	period of 7-19-202	0 to 9-8-2020, for patient #4			(verbal/physical/emotional,			
		or skilled nursing under			sexual), neglect, misappropri	ation		
		thorization (PA) to allow the			of property or injuries of unkr			
	mother to work var	ried hours and attend school.			origin have been identified. T			
					Administrator and Director of			
	_	w with patient #4's mother on			Clinical Services completed a	a		
		.M., the mother of patient #4			100% review of all patient			
	stated patient #4 is	unable to make needs known			complaints in 2020 regarding			

due to significant speech, cognitive, sensory, and

Review of a video recording taken in the home of

developmental impairment.

ZP5711

abuse, neglect or exploitation in

2020. Those complainants have

Administrator and/or Director to

been contacted by the

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED
		15K141	B. W	ING		09/18/2020
				STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	L			COUNTY LINE ROAD SUITE 10	05
TOGFTH	IER HOMECARE				NWOOD, IN 46143	
	Г				, <b>.</b>	<u> </u>
(X4) ID		STATEMENT OF DEFICIENCIE		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		DATE
	l -	na crack you," could be heard			ensure they have no further	1
	from a person who was off camera.				concerns regarding the report	
	Daview of a Client Legging Deport detect				complaint, or any ongoing issu	
	Review of a Client Logging Report, dated				or concerns related to Patient	
	8-24-2020, evidenced the agency had determined				Rights. The Administrator has	
	employee B, a registered nurse assigned to the care of patient #4, said to patient #4, "I'm gonna				verified that all complaints,	ar
	_	rse admission constituted			including allegations of abuse neglect have been thoroughly	
	verbal abuse.	150 admission constituted				
	verbar abuse.				investigated and resolved, and further actions are required to	•
	3. Review of a com			ensure patient safety. Addition		
	patient #1, evidence			all employees were re-educate	•	
	1 ~			on patient rights, including the	•	
	employee A, had taken, without permission, patient #1's handicap parking sticker, and not				right to be free from all abuse,	
	returned it.	p parking sticker, and not			injuries of unknown origin and	
	returned it.				misappropriation of property, a	
	During a telephone	interview with patient #1 on			well as the right to voice	25
		A.M., patient #1 indicated			grievances/complaints to the	
		to the agency that employee			agency. The Administrator will	l he
		handicap parking sticker			responsible for ensuring that a	
	without consent and				inactive employee receives all	-
					in-services distributed as part	
	Review of a compla	aint dated 8-19-2019, at 4:07			the Agency's plan of correction	
	_	tient #1 complained home			prior to being switched to "acti	
	_	employee A, had taken			status and placed in the sched	
		icker without consent. The			To ensure that the Agency's	
		n evidenced would look to			investigative process is thorou	ıgh
	return the handicap	sticker to patient #1. The			and clear, the Agency's Patier	•
	resolution failed to	document the misappropriated			Complaint Policy (C-381) was	
	property had been r	etrieved from employee A,			modified to include more detail	
	HHA, and returned	to patient #1.			instructions for obtaining and	
					reviewing evidence in the	
	4. On 9-4-20, at 2:	15 P.M., the administrator			investigative process, includin	g
		ong of employee A to take			requesting, reviewing, and	
		p parking sticker for any			documenting photographic, au	ıdio,
		s a misappropriation of patient			or video submissions related t	
		n asked for additional			the complaint. An Investigation	•
	pertinent information	-			Guidance form was created to	)
	1	administrator and DOCS			further facilitate a thorough	
	indicated having no	thing further to present for			investigative process and will	be

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15K141	B. W	ING _		09/18/	/2020
		<u> </u>	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			COUNTY LINE ROAD SUITE 10	15	
TOGETH	IER HOMECARE				IWOOD, IN 46143	.5	
TOOLIII	ERTIONEOTICE			OIVEEIV			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	review.				utilized for each complaint to		
					ensure a thorough and comple		
	410 IAC 17-12-3 (t	o)(4)(A)			investigation with proper follow	-	
					The complaint form has also b		
					updated to ensure that a detai	led	
					and responsive resolution is		
					provided to the patient followir	-	
					the Agency's investigation. All		
					internal employees were educ	ated	
					on the new complaint policy		
					(C-381) and complaint forms.		
					The Administrator and Directo		
					Clinical Services are responsi		
					for conducting and directing A		
					complaint investigations to en		
					patients are free from all abus		
					injuries of unknown origin and		
					misappropriation of property a	t all	
					times. The Administrator and		
					Director of Clinical Services w		
					audit 100% of complaints for 6		
					days to ensure compliance wi	ın	
					agency policy and state and	-4-	
			1		federal requirements. All patie have been educated at the sta		
					care on their patient rights,	ait Ui	
			1		including the right to be free fr	om	
					all abuse, neglect or exploitati		
			1		as well as the right to voice a	O11,	
					complaint and the options for		
			1		doing so, including contacting	the	
			1		Agency and calling the ISDH		
					complaint hotline. This information	ation	
					is present in all patient homes		
					easy access. The agency will		
					continue to utilize supervisory		
					visits and client satisfaction		
			1		surveys as an additional outle	t to	
					receive patient complaints and		
					remind patients of their rights		
	i		1		1		1

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 10 of 84

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15K141	B. W	ING		09/18/	/2020
NAME OF D	ROVIDER OR SUPPLIE	0		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUFFEIE	X.			COUNTY LINE ROAD SUITE 10	)5	
TOGETH	ER HOMECARE			GREEN	NWOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					bring complaints to the attenti	on of	
					the Agency.		
					The Director of Clinical Service		
					and Administrator are respons		
					for monitoring these corrective		
					actions to ensure the deficien corrected and will not recur.	Cy is	
					corrected and will not recur.		
G 0436	484.50(c)(5)						
	Receive all service	es in plan of care					
Bldg. 00		es outlined in the plan of					
Ŭ	care.	•					
			G 0	436	G436		11/11/2020
	Based on record re	view and interview, the agency			All internal employees have b	een	
	failed to ensure pat	ients received all the care visits			re-educated regarding the nee		
	ordered in the plan of care for 1 (Patient #1) of 4				follow the ordered frequency a		
	patients with home	health aide only services, of 6			duration range outlined in the	Plan	
	patients whose clin	ical records were reviewed.			of Care. The Administrator will	ll be	
					responsible for ensuring that	any	
	The findings include	led:			inactive employee receives al	I	
					in-services distributed as part		
		, "Services on Hold," last			the Agency's plan of correction		
		-21-19, evidenced the policy			prior to being switched to "act		
		ill be placed on hold when			status and placed in the sche		
		to receive services in the home			Any deviation from the ordere		
		on, interruptions in therapy			frequency and duration range		
	-	onse (infusion), or travel			continue to be documented w		
		service area. Services may be			missed visit note or suppleme		
		periods of time within a sixty  ut cannot be extended if the			order and communicated to the		
		in the certification period			Physician. The Agency will make up any	ake	
		suspended the Director of			every effort to make-up any missed visits within the work		
		esignee will place the services			week.		
		on identified The physician			WCGN.		
		the change in condition or			The Director of Clinical Service	es or	
		ipitating the change.			designee will audit 100% of	.55 01	
	-	ill be obtained if there is a			processed schedules for 60 d	avs	
	· ·	or treatments to be provided			to ensure missed visit notes of	-	
		aintain regular contact to			supplemental orders are sent		
		ated date for services to			the Physician for any schedul		

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 11 of 84

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	f '		ONSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL			
		15K141	B. W	ING		09/18/	2020		
	PROVIDER OR SUPPLIER	· :	-	555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 IWOOD, IN 46143	5			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDEDIC DI AN OF CODDECTION		(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE		
	resume, if a pre-det	ermined resumption date has			falling outside of the ordered				
		established When it is			frequency and duration. Once				
	_	patient services will not			100% compliance has been				
		inticipated time, the Director of			maintained for 60 days, the				
	Clinical Services or designee will contact the				Administrator or Director of				
	patient/family and the appropriate staff members			Clinical Services will audit 10% of					
	and initiate the discharge process. The physician				patients quarterly as part of th				
	will be notified of planned discharge."				Agency's QAPI program to en	sure			
	Review of an undat			continued compliance.					
				The Administrator and Directo	r of				
	patients rights enumerated, "Rights and Responsibilities," evidenced, " Together				Clinical Services are responsi				
	_	steet the exercise of these rights			for monitoring this corrective	oic .			
	_	nentation showing that they			action to ensure the deficiency	/ is			
		the following rights: To			corrected and will not recur.	, .0			
	_	outlined in the plan of care "							
		•							
	Review of the clinic	cal record for patient #1,							
	evidenced a start of	care of 7-5-19, and contained							
	_	e certification period of 7-5 to							
		ers for home health aide (HHA)							
		equency and Duration: 1							
		s/week X [for] 9 weeks							
		rior authorization] Program							
	_	has chosen to schedule PA							
		-5 hours/day X 3-5 days/week,							
	1	-2 days/week, 0.5- 4 hours/day							
		Medicaid Waiver Program							
	•	has chosen to schedule							
		llows: 3-7 hours/day X 3-5 rs/day X 1-2 days/week, 4-8							
	1	ys/week." The primary							
		iple Myeloma. Functional							
	_	cluded "endurance."							
	initiations fisted file								
	HHA prior authoriz	zation hour duties enumerated							
	on the plan of care included: Housekeeping:								
	_	Weekly and PRN [as needed;]							
	Take out trash; Clea	an bathroom(s): Weekly and							
	PRN: Light Housek	reeping: Every visit: Assist							

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 12 of 84

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	1 1		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED	
		15K141	B. W	ING		09/18/2020	
	PROVIDER OR SUPPLIER	·	-	555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 IWOOD, IN 46143	05	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	NO AMBERICAN AND OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	with Laundry, PRN	; Assist with dishes: Every					
		N; Vacuum/Sweep weekly and					
	PRN; Dust Weekly	and PRN; Bathing: Shower					
	chair/bench to be used during bathing; assist with Shower: PRN; Hygiene and Grooming: Assist with Shampoo PRN; Assist with Nail Care PRN; Assist with Dressing, PRN; Hair Care PRN; Peri Care PRN; notify Clinical Supervisor if no B.M. [bowel movement] in 3 days; document last B.M.date PRN; Assist to Commode PRN; Handling/Bringing meds [sic medications] to patient PRN; Verbal Medication Reminders PRN; Assist with wheelchair PRN; Assist with walker as needed for ambulation PRN; Assist with						
		rs every visit; Assist with cane					
	as needed for ambu						
		/Assist with Active Range of					
	-	Prepare/Serve Meals Every					
	_	uids Every visit; May assist					
	_	re Every visit; Bring in mail					
	PRN.						
	Daview of notions #	11 start of some community ansity					
	_	1 start of care comprehensive 7-5-2019, evidenced "Patient					
	· ·	nary caregiver able to provide					
	the hands on care h						
	the hands on care in	e/she requires.					
	Review of the HHA	care plan dated 7-5-2019,					
		equency/Duration: 1 visit /day					
		The document evidenced the					
	following schedule:	"M [Monday]-Sat [Saturday]					
	PA [prior authoriza	tion] = 9 AM to 12 P; W					
		5 PM Sun [Sunday] PA = 9					
	AM to 11 AM, W =	= 11 AM to 5 PM."					
	Review of the HHA	visit notes, for PA and					
		vidence any care visits were					
		3-19 and Thursday, 8-22-2019.					
		equency order of 6-7 visits per					
	_	s only 5 care visits were					

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 13 of 84

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	OATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	LETED	
		15K141	B. W	ING		09/18/	/2020	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIER	2			COUNTY LINE ROAD SUITE 10	)5		
TOGETH	IER HOMECARE				NWOOD, IN 46143			
(X4) ID		STATEMENT OF DEFICIENCIE		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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	*	of the home health aide (HHA)						
		and Waiver, failed to evidence						
	1 -	made on Monday, 8-26 and						
	· ·	The plan of care frequency						
	_	er week was not met as only 5						
	_	vided. The clinical record						
		ow patient #1's needs for						
		L's (activities of daily living)						
	were met in the abs	ence of the ordered care visits.						
	On 9 -4-2020, at 2:	15 P.M., the above findings were						
		ministrator and the DOCS.						
	When asked for additional pertinent information, explanation, or documentation, the administrator							
	and DOCS indicate	d having nothing further to						
	present for review.							
			İ					
G 0482	484.50(e)(1)(i)(B)							
	Mistreatment, neg	lect or abuse						
Bldg. 00	. , , ,	t, neglect, or verbal,						
	mental, sexual, ar							
		of unknown source, and/or						
		of patient property by						
	1 .	services on behalf of the						
	HHA.							
			G 0	482	G 482		11/24/2020	
		view and interview, the home			All internal staff members hav			
		l to document as a complaint			received re-education regarding	-		
		to document a responsive			the proper process for compla			
		plaint of physical and verbal			reporting and documentation a			
	· ·	injury of unknown origin, for			well as patient rights via a nev			
		minor patient, whose clinical			in-service. This in-service incli			
		d and whose plan of care			a review of the updated policie			
	_	ours skilled nursing care for			and forms, including C-381, C			
		nditions, of a sample of 22			and B-340, new complaint for			
		ed skilled nursing services for nditions, in a current census of			and new Investigation Guidan			
		om the agency provided care.			form, as well as a review of th	E		
	100 paneins for wh	om me agency provided care.			Patient Rights and	ı		
	The findings includ	ad			Responsibilities document. All			
l	The findings includ	cu.			employees have been re-educ	วลเษน	I	

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 14 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	MENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/18/2020	
	OF PROVIDER OR SUPPLIED THER HOMECARE	₹		555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 IWOOD, IN 46143	5	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL  DESCRIPTION OF THE PROPERTY OF THE PRO		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	Review of an undar patients rights enur Responsibilities," e Homecare must pro and maintain docur have complied with free from verbal, m abuse, including in neglect, and misapp voice grievance care that is (or fails the lack of respect anyone who is furm agency and must not discrimination or reagency must invest regarding treatment furnished, or regard patient or the patient furnishing services must document bot resolution of the concept of the concept of the patient or the patient furnishing services must document bot resolution of the concept of the patient of the concept of the patient of the appropriate of the appropriate of the patient of the steps of the steps of the patient of the steps of the steps of the patient of the steps of the	eprisal for doing so. The igate complaints made tor care that is (or fails to be) ling the lack of respect for the nt's property by anyone on behalf of the HHA, and h the existence and the		TAG	about patient rights with emph on the patients' rights to be free from verbal, physical and emotional abuse and neglect. Administrator will be responsite for ensuring that any inactive employee receives all in-service distributed as part of the Agent plan of correction, prior to being switched to "active" status and placed in the schedule. All Together Homecare patients here to outstanding complain including concerns regarding verbal, physical, sexual, or meabuse or neglect, misapproprisof property or injuries of unknown origin. No additional concerns regarding new or previously reported or unreported abuse (verbal/physical/emotional, sexual), neglect, misappropriatof property or injuries of unknown origin have been identified. Additionally, the Administrator Director of Clinical Services contacted all individuals who from the complaints in 2020 regarding abuse or neglect to ensure the are no further concerns regard the reported complaint, or any ongoing issues concerns relation to Patient Rights.  The Administrator and Director Clinical Services are responsited for complaint investigations to ensure all complaints made and thoroughly investigated and documented and to ensure	asis ee The ole ces cy's ng l nave ee ts, ental ation own and iled ere ling ed r of ole	DATE

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 15 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COMI	E SURVEY PLETED 8/2020
	PROVIDER OR SUPPLIE	R	555 E	ADDRESS, CITY, STATE, ZIP C COUNTY LINE ROAD SU NWOOD, IN 46143		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	Reporting Abuse/N Patients," last revie evidenced the polic right to be free fror verbal abuse, as we Purpose To prot either by physical of dependence on inst vulnerable to abuse are a list of commo in children and adu findings is an indic as a guide: Uner physical injuries (b)  Review of policy e last reviewed/revis policy stated, "The investigation are pa Improvement Prog reviewed by Admin Services/designee, further action is ne reviewed by the Ad determines opportu- improvement or wh "  Review of the clini evidenced a date of patient, and patient Patient #4 was diag was developmental expressions of wor seizure activity, fal G-tube [gastrostor medications (include	ntitled, "Identifying and leglect/Exploitation of swed/revised 8-21-2019, by stated, "Patients have the mental, physical, sexual, and ell as neglect and exploitation sect those persons who are, or mental disability or itutional services, particularly or neglect The following on indicators for abuse/neglect lts. The presence of these ation and should only be used explained or poorly explained ruises, burns) "  Intitled, "Incident Reporting," ed 8-19-2019, evidenced the reporting of incidents and the art of the agency's Performance ram Incident reports are instrator/Director of Clinical who will then determine what eded After the report is diministrator/designee, he/she unities for performance nether to continue monitoring  cal record for patient #4  Fibirth of 9-26-2002, a minor #4 had a parent as guardian. Incosed with Dravet Syndrome, ly delayed with very few verbal ds, had a gait abnormality, high I precautions, stand-by assist, by feedings, multiple ling seizure medications,) ons, bleeding precautions,		patients are free from a injuries of unknown ori misappropriation of protimes. The Administrat Director of Clinical Ser audit 100% of patient of 60 days to ensure owith the Agency's cominvestigation process. Adays of 100% compliant Administrator and Directinical Services will apatient complaints each as part of the Agency's Program, to ensure comaintained. The Administrator and Clinical Services are reformonitoring these conactions to ensure the discovered and will not reform the following the services are reformed to ensure the discovered and will not reformed to the following these conactions to ensure the discovered and will not reform the following these conactions to ensure the discovered and will not reform the following these conactions to ensure the discovered and will not reform the following these conactions to ensure the discovered and will not reform the following the follo	gin and operty at all or and vices will complaints compliance plaint After 60 nce, the ctor of udit 20% of th quarter, s QAPI mpliance is  Director of esponsible orrective deficiency is	
i	1 ^ *	~ .	1	I		1

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 16 of 84

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	00	COMPL	
		15K141	B. WIN	G		09/18/	2020
			<del>' т</del>	STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t .			OUNTY LINE ROAD SUITE 10	5	
TOGETH	ER HOMECARE				WOOD, IN 46143	•	
			, 1				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	P	REFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	* *	need for intermittent oxygen					
	·	temperature instability related					
	_	cognitive impairment related					
	to developmental de	elay.					
	Om 0 8 2020 at 2:01	1 D.M. dywing talanhana					
		P.M., during telephone parent guardian of patient #4,					
	-	concerns related to					
	_	issues, stated, "Which					
		ve been so many." The parent					
		ntacted agency management					
	_	s to request a visit from the					
		ut the agency had failed to					
		e mother stated on or about					
	_	#4 refused to go into the					
	_	eviously had not been an					
	_	ed saying the word "belt",					
		patient #4 had not normally					
	-	ted the bruise matched the					
	_	s of the buckle on the gait belt					
	and confirmed havi	ng taken photographs. The					
	parent stated having	g found the gait belt in the					
	living room, which	was unusual because no one					
	used it, and the gait	belt was stored in a closet.					
	The parent stated pa	atient #4 is now frightened of					
	-	arent was unable to recall the					
		e was identified; stated having					
	` '	ting the bruise, when patient					
		en prompted, stated the nurse					
		also indicated having a video					
	-	parent alleged showed					
		ncy registered nurse, having					
	said "I'm going to c	rack you" to patient #4.					
	n e	1 4 14 10 24 2020					
		ned entry, dated 8-24-2020, into					
		Report made by employee D,					
	registered nurse case manager, evidenced employee D made a home visit at patient #4's						
		-					
	_	stered nurse (RN,) and was					
	employee B, a regis	sicied fiurse (INIV.) alla was					

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

Event ID: ZP5711 Facility ID: 013867

If continuation sheet Page 17 of 84

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	r í	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 09/18/	ETED
	PROVIDER OR SUPPLIER			555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 WOOD, IN 46143	5	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	entry evidenced the around 10 A.M. and the "full-time nurse her [patient #4's] ga cameras located every bathrooms. The pare believing the incide the bathroom, becaut the bathroom, and to show patient #4 length Report entry by RN "called administration." The RN parent send the vide administration and begin." The parent full-time nurse is not during this investige document this report Review of 2 videos provided by the most the following:  Video #1(img_8484 living room, a dining with a Dutch door of are visible at any time Audio was heard of "Stop [first name of of patient #4] I'm Video #2 (img_848 seated, possibly in the were exposed and the video. A purple brut upper right thigh. The happened?" Patients	rent of patient #4 stated ant may have occurred inside use there is no video camera in the other home cameras failed being hit. The RN Logging I, employee D, evidenced on to inform them of the I, employee D, requested the teos and pictures "to further investigation will was informed "the patient's ot allowed inside of the home ation." The agency failed to					

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 18 of 84

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING		COMPL	(X3) DATE SURVEY COMPLETED 09/18/2020		
	PROVIDER OR SUPPLIER	2	555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 IWOOD, IN 46143	)5	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	).TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	DATE
	"What happened? I	Did you say the nurse? The				
	nurse, yes or no?" F	Patient #4 replied, "Bath."				
	The parent was hear	rd asking a version of "what				
	happened" approxir	mately 4 times and a version of				
	"Did the nurse hurt you" approximately 10 times.  The clinical manager indicated, on 9-10-2020, at 2					
	P.M., when queried	about the abuse/neglect				
	allegations related t	to patient #4, having known a				
	little about patient #	#4, but not having known the				
	care plan and other	information well because				
	"[name of patient #4] is not my patient." When					
	queried concerning	the absence of a complete				
	investigation related	d to the observed injury of				
	unknown origin; ab	sence of physical assessment				
	documentation by t	he supervisory nurse, to				
	include measureme	nts, assessment of the bruise, a				
	pain assessment, an	d a full integumentary				
	assessment to detec	et any further injuries of				
	unknown origin, the	e clinical manager stated there				
	was no physical ass	sessment because "that's not				
	what we were there	for." On 9-11-2020, about 2:49				
	P.M., during a seco	nd query related to the failure				
	to address allegation	ns of abuse, the clinical				
	manager asked, "W	hat else did you want us to				
	do?" When asked v	why a complete investigation				
	was not conducted,	as a means to resolve the				
		ns of abuse/neglect, the clinical				
	manager indicated t	the Incident Reporting Form				
		ging report documented all the				
	actions the agency l	had taken.				
		ndicated, when queried on				
		eximately 2 P.M., having "made				
		propriate agencies." Review				
		d, "Incident Reporting Form,"				
		videnced "Agency made all of				
		ts for the allegation made				
	I -	, CPS, MD and CICOA were all				
	notified of the situa	tion. CPS is currently				

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 19 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		r /	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  09/18/2020	
	PROVIDER OR SUPPLIER		555	E COL	RESS, CITY, STATE, ZIP COD JNTY LINE ROAD SUITE 10 DOD, IN 46143	)5	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	1 '	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	ongoing investigation [employee B, RN] is asked for a list of parasked for a list of parasked for a list of a different administrator stated administrator stated administrator stated administrator stated list of a list of a list of a docum form", under Required following items were listed list of a list o	remains suspended." When attents to whom the affected are, the administrator patient names. When queried had contacted these families to neglect concerns, the "No." When queried if the eviewed all the videos of patient #4, the "No."  The titled, "Incident Reporting ared Reporting To, the remarked:  The marked:  The					
	indicated having videscribed above. T	P.M., the administrator ewed videos #1 and #2, he administrator indicated n/mother did not notify the					

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 20 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		(X2) MULTIPLE ( A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/18/2020	
	ROVIDER OR SUPPLIER		555 E	T ADDRESS, CITY, STATE, ZIP COD ECOUNTY LINE ROAD SUITE 10 ENWOOD, IN 46143	5
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	agency of the bruise abuse, but the agence allegations of the all supervisory nurse, etwice When asked for addrexplanation, or doct and DOCS indicated present for review.  An immediate jeopa under 42 CFR 484.58-24-2020, and was administrator was not p.M. The agency's removal of immediate determined to have	(1)	TAG	DEFICIENCY)	DATE
G 0484	484.50(e)(1)(ii) Document compla	int and resolution			
Bldg. 00	complaint and the	the existence of the resolution of the complaint;			
	failed to document or resolutions to patier complaints reviewed.  The findings included	riew and interview, the agency completed and responsive at complaints for 12 of 16 d from 2019 and 2020.  ed:  dated start of care packet, with merated, "Rights and videnced, " Together tect the exercise of these rights mentation showing that they	G 0484	G484  All internal employees have be re-educated on the Agency's complaint policy (B-341). All internal employees have also educated on the requirement to conduct and document a thore investigation, to include a complete and responsive resolution in the complaint write-up, and to report said	been to

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 21 of 84

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  09/18/2020	
	PROVIDER OR SUPPLIER		555 E	ET ADDRESS, CITY, STATE, ZIP COD E COUNTY LINE ROAD SUITE ENWOOD, IN 46143	105
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
TAG	have complied with voice grievances care that is (or fails the lack of respect f anyone who is furniagency and must no discrimination or reagency must investire regarding treatment furnished, or regard patient or the patient furnishing services must document both resolution of the construction of the	prisal for doing so. The gate complaints made or care that is (or fails to be) ing the lack of respect for the tt's property by anyone on behalf of the HHA, and in the existence and the implaint "  y entitled "Patient/Family last reviewed/revised ed the policy stated," bolish a procedure for into the appropriate person to provide a response to the implaints regarding treatment, will be documented on the he person receiving the et and forwarded as soon as opriate director or to the for investigation action and inswith a complaint will be a taken to investigate the to of the process and the date.  The plaint from patient (Patient #7,) and the dissatisfaction with plantaide (HHA) prior and waiver hours. The sto resolve the complaint were	TAG	resolution to the complainar complainant will be contacted the Agency, in accordance of Agency policy (B-341) to report the results of the Agency's investigation and the resolution the complaint.  The Director of Clinical Services and Administrator are responsive resolutions at all times. The Director of Clinical Services Administrator will review 10 complaints for 60 days to endeath complaint includes documentation of a complete responsive resolution befitting complaint, as well as documentation that the resolution was communicated to the complainant. After 60 days 100% compliance, the Administrator and Director of Clinical Services will audit 2 complaints quarterly, as part the Agency's QAPI Programensure continued compliance. The Administrator and Director of Clinical Services are responsive resolutions to ensure the deficience corrected and will not recursive.	nt. The ed by with port tion of vices onsible ons and own of nsure te and ng the olution of tof n, to be ency is
		to resolve the complaint were working to restaff. The aide			

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 22 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K141	B. WI	NG		09/18/	/2020
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			COUNTY LINE ROAD SUITE 10	5	
TOGETH	IER HOMECARE				IWOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		nt] wanted to come back FT					
		sked not to return d/t [sic due					
		smoking CICOA [sic Central					
	Indiana Council on Aging] notified to see if they						
		hours at all. Clinical					
		at today for RCT, [sic					
		ssment] so if there's a change					
		on assessment, Agency will					
		nd can try to request Pt [sic					
		c of ordered care hours per					
	week] from MD." The complaint was documented						
	as resolved on 5-15-2020. The complaint resolution failed to evidence the outcome of the						
		prehensive assessment,					
		inant was eligible for more care					
	_	nange in condition, and					
		's physician had been					
	_	nate ordered plan of care					
		on documented was					
		not document a responsive					
	resolution to the pa						
	resolution to the pa	tient's complaint.					
	_	ent (Patient #8) care complaint					
		videnced a complaint the					
		he day before was only 10					
		plaint was documented					
		19, based on an investigation.					
		lution failed to evidence if the					
	1 -	t, and care provided by the					
		, were reviewed and were					
	· ·	plan of care orders with all					
	care orders complete	ted.					
	5 D	(D. 1. 1. 10)					
		ent (Patient #9) care complaint					
		enced a patient complaint					
	alleging the nurse, employee DD, spent visit time						
	_	ending to patient's needs.					
		gs evidenced the identified					
		ed by 2 other families not to					
	return for skilled nu	irsing care because the nurse					

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 23 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/18/2020
	PROVIDER OR SUPPLIER	3	555 E	ADDRESS, CITY, STATE, ZIP COE COUNTY LINE ROAD SUIT NWOOD, IN 46143	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE COMPLETION
	focus on care of per was documented as CSM [customer ser identify new nursin is off " The document and the care visits for were being provide care. The document and did not resolve complaint in relation patient's needs, and staffing in place.  6. Review of a pating dated 8-2-2019, evirelated to HHA not Agency review of the HHA was late to the schedule of visits good to see about finding will continue to state could be found or the with our services. It through Indeed to the area in which the complaint was documented to address hor failed to	uch of personal life rather than diatric patient. The resolution 17-17-2019, "schedulers and vice manager] are trying to g staff for when primary nurse amented resolution failed to ing staff had been identified for the patient in the complaint dias ordered on the plan of the resolution was incomplete the allegations in the into failure to attend to the ina determination of nurse the complaint denced a patient complaint reporting to shift on time. The complaint evidenced the endog back 3 months evidenced was not provided. "Actions "Agency will contact CICOA and different provider. Agency off client until a new provider the family becomes satisfied Agency will also post an adery to find additional staff in the patient resides." The amented as resolved on the unented resolution was not insive because the agency with the plan of care ordered care reduled/staffed to meet the			
	dated 8-19-2019, ev who performed pate	tent (Patient #10) care complaint videnced a complaint the nurse ient's bowel program was late isit. Review of the section,			

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 24 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  15K141	A. BUILDING B. WING	00 00	COMPLETED 09/18/2020
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10	75
TOGETH	ER HOMECARE			NWOOD, IN 46143	J.
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION ngs:" evidenced "In speaking	TAG	BEIGERETT	DATE
	_	l looking at verified schedules,			
	_	ne missed visits in [name of			
		The team is working diligently			
	-	o assist in the bowel program.			
		heduling, it was also			
		patient's mother [name of			
		bout the lack of staff "			
	Review of the section				
		inistrator has reached out			
	again, to [name of	person] at CICOA about			
	finding another pro-	vider that can better suit their			
	needs As of right	now, at 12:46, Agency has			
	not heard back from	CICOA " The complaint			
	was documented as	resolved on 8-20-2019. The			
	documented resolut	ion (Actions Taken) failed to			
	evidence an outcom	e for the complaint allegations			
	_	to include whether the agency			
		assigned nurses to meet the			
	-	or whether the patient had			
	chosen to select and	other provider.			
	-	ent (Patient #1) care complaint			
		4:07 P.M., evidenced a patient			
	-	e health aide (HHA) employee			
		ed in patient #1's home,			
		the home and family, and			
		ntent on You Tube without			
		HHA, employee A, smoked			
		tient's bathroom. Review of the			
	-	d it was documented as			
		d by the administrator, on			
		P.M. The documented actions			
		"Caregiver [sic employee A] is			
		with the agency due to not			
		protocol. Administrator has giver to get the parking pass			
		c employee A] stated that she			
		the following business day.			
	~	y re-staffed the client and are			
	The nave temporarii	y to started the effect and are			

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 25 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  15K141		ILDING NG	00	COMPL 09/18/	ETED
	PROVIDER OR SUPPLIER			555 E C	DDRESS, CITY, STATE, ZIP COD OUNTY LINE ROAD SUITE 10 WOOD, IN 46143	5	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE 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
	working to find a per documented resolution responsive because ensure patient #1's horeturned and the resolution of the nature and scope #1's privacy, e.g. who Insurance Portability violation also occurred as the privacy, e.g. who Insurance Portability violation also occurred as the privacy, e.g. who Insurance Portability violation also occurred as the privacy, e.g. who Insurance Portability violation also occurred as the privacy, e.g. who Insurance Portability violation also occurred as the privacy, e.g. who Insurance Portability violation also occurred as the privacy, e.g. who Insurance Portability violation also occurred as the privacy, and the privacy in	ermanent solution." The ion was not complete and there was no follow up to handicap parking pass was colution failed to evidence the id been reviewed to determine to of the violation of patient hether or not a HIPAA (Health y and Accountability Act) red.  Interview with patient #1 on A.M., patient #1 indicated to the agency and also You cost taken by HHA, employee in patient #1's home. Patient concerned about images and costed videos which contained tion about patient #1 and Patient #1 stated You Tube video posts.  5 P.M., the administrator led employee A to come into the allegations in patient #1's d for drug testing. When I, the administrator indicated termination from employment rate with a complaint A, employee A, had taken p parking sticker, and the ethe parking sticker was					
1	1		1				Ī

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 26 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  15K141	A. BUILI B. WING	DING	00	COMPL 09/18/	ETED
	PROVIDER OR SUPPLIER		Ę	555 E C	DDRESS, CITY, STATE, ZIP COD OUNTY LINE ROAD SUITE 10 WOOD, IN 46143	5	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID EFIX CAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	information, the adm The administrator st employee A to take sticker for any reaso pertinent information documentation, the indicated having not review.  10. Review of a con 8-26-2019, evidence related to staffing. If found out there have primarily on the west 1st, 2019, the agenc Right now, Togethe much staff that can it Update: I have spok let her know our plat care of " The doc evidence staffing ne weekends, had ident the patient's care need incomplete and non- to get weekends tak of having identified care visits as ordere  11. Review of a con evidenced a patient related to staffing. If agency documented previous aide has be schedule and we are different aides until [sic HHA.] I also re	ninistrator responded, "No." tated it was wrong of patient #1's handicap parking on. When asked for additional					
	protocol to our clier	nts/families. Agency will					

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 27 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15K141		UILDING	00	COMPL 09/18/	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	·		ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10	5	
TOGETH	IER HOMECARE			IWOOD, IN 46143		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  R I SC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION
TAG	identify a new aide CICOA in the loop. documented as reso resolution failed to the allegations in th not documented car ascertain if the ager (staffing) as ordered "Actions Taken" se the allegations, but been implemented a complaint.  12. Review of a pa complaint dated 10- complaint related to "Investigative Findi the schedule and we however, we were a those shifts. Tradit but we've had a tou there, whether they [name of patient] do complaint was docu "We informed [nam getting job postings needs. We apologic let him know we we communicated duri they [sic patients] h provider and at this stay with Together resolution was not or responsive to the co planned, which hav implemented to add regarding staffing, ve	and keep both the family and "The complaint was dived on 9-3-2019. The be responsive and complete to e complaint. The agency had be visits had been reviewed to explain to address failed to document a plan had and had resolved the patient's  tient (Patient #13) care -7-2019, evidenced a patient o staffing. Under ings, Administrator reviewed e did have 3 call offs in 4 days, able to identify staff for one of ionally, we have had coverage, gh time keeping aides out do not want to go back, or ones not want them back." The amented as resolved 10-8-2019, the of patient] that we would be to up specific to their open and for the inconvenience and bould do our best. It is ong every supervisory visit, that ave the right to choose their time, they have decided to Homecare." The documented complete had was not complaint. Future actions the not been documented as aress the patient's complaint were not a resolution.	TAG	DEFICIENCY		DATE

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 28 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  15K141	A. BUILDING B. WING	E CONSTRUCTION  G 00	COM	E SURVEY PLETED 8/2020
	PROVIDER OR SUPPLIER		555	EET ADDRESS, CITY, STATE, Z E COUNTY LINE ROAD EENWOOD, IN 46143		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE FHE APPROPRIATE	(X5) COMPLETION DATE
	complaint dated 5-6 employee JJ, had no care to patient # WV sleeping on the job. evidenced employee asleep on the job, an providing care listed Taken" evidenced " gave [sic HHA] ver performance and ren Agency has remaind and [his/her] family case with someone documented resolut agency had impleme provide the ordered patient's needs.  14. Review of a par complaint dated 6-1 HH, home health air assigned work shift, returning to duty for telephone a lot whill spouse.) The comp resolved on 6-18-20 removing employee resolution failed to care and provision of been negatively afformisconduct.  15. Review of a par complaint dated 7-1 the HHA had slept to assigned shift, an 30-45 minutes during	tient (Patient #14) care 3-2020, alleged the HHA, but been providing adequate WW and this HHA was "Investigative Findings" but Jadmitted to having fallen and was re-educated on all on the care plan. "Actions Agency re-educated aide and bal warning about job moved from patient schedule. but in contact with the patient about re-staffing [him/her] they approve of. The ion failed to evidence the ented, not just planned, to care visits to meet the  tient (Patient #14) care 2-2020, related to employee de, having brought child to that taking lunch breaks and not an hour, and using the e on duty (arguments with laint was documented as 120, with agency action of the HH from assigned shifts. The document if the delivery of of HHA patient services had betted by the HHA's  tient (Patient #15) care 3-2020, evidenced a complaint while on shift, had arrived late d was taking lunch breaks of an assigned shift, and changed bound patient's brief				

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 29 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	r í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/18/	ETED
	PROVIDER OR SUPPLIER	<b>R</b>		555 E C	DDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 WOOD, IN 46143	)5	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	log rolling patient vunderneath patient. documented as reso competency issue of bedbound patient at having provided veemployee GG. The the agency had follog GG, HHA, while pot the brief of an incompliant dated 7-1 concerns for patient evidenced, "Staffin of employee C, reg from the schedule. have the resources recruiting." The coresolved on 7-17-20 Agency has inform issues as well as CI on Aging.] We spemanager] and she is pick list to identify their needs. If we follower, we will continue are taking it day family the best we resolution failed to but described a plan patient #4's care necare, or having doc satisfied with the properties.	tient (Patient #16) care 16-2020, related to staffing t #4. "Investigative Findings" g has been tough since [name istered nurse] was removed The agency does not currently to staff but are actively implaint was documented as 020, with "Actions Taken: ed the family of the staffing COA [Central Indiana Council loke with [name of CICOA case is aware, and the family has a an agency that can support find a nurse who can take the inue to staff. In the meantime, is by day to try and support the can." The documented evidence completed actions, in to proceed without meeting eds as ordered on the plan of tumented the complainant was roposed resolution.  It 2:10 P.M., the above concerns in the administrator and director					
		(DOCS,) who stated the					

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 30 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLET			ETED		
		15K141	B. W	ING		09/18/	2020	
	ROVIDER OR SUPPLIER		<b>_</b>	555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 IWOOD, IN 46143	)5		
(V4) ID	CLIMMADY	CTATEMENT OF DEFICIENCIE	1	ID	T		(V5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG		LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	responsive. When opertinent explanation documentation, the	tation was not complete and queried for additional on, information, or administrator and the DOCS and further to present.						
G 0526	484.55(c)							
Bldg. 00	Content of the comprehensive assessment							
			$G_0$	526			11/11/2020	
	Based on record rev	view and interview, the agency		220	G526		11/11/2020	
		registered nurses conducted						
		complete comprehensive			All RN Clinical Supervisors ha	ive		
		is for care planning for 1			been re-educated on the			
		ents who received skilled			importance of conducting and			
		stal sample of 6 patients whose			documenting a thorough			
	clinical records wer	e reviewed.			comprehensive assessment a	t		
	The findings includ	ed:			re-certification and not documenting "see POC" or "se med profile" with regard to DN			
	Review of a policy.	"Comprehensive Patient			settings, medication information			
		nced the policy stated, "A			other details regarding patient			
		nized, comprehensive and			status or care. The Director of			
	-	t, consistent with the patient's			Clinical Services reviewed pat			
		ill be completed for all patients			#4's plan of care to ensure it			
		rmine the appropriate care,			contained the detailed informa	ation		
	•	ces to meet patient initial and			related to her clinical status,	=		
		eds To make care,			including respiratory treatmen	ts,		
		e decisions based on			seizure precautions and DME			
	· · · · · · · · · · · · · · · · · · ·	ped about each patient's needs			settings. The record is 100%			
	-	response to care To			compliant.			
		neasurement. To measure			The Director of Clinical Servic	es or		
	processes of care in the agency. To identify				RN designee will audit 100% o			

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 31 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		15K141	B. W	ING		09/18/	2020
			<u> </u>	CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10	15	
TOOFTH						15	
IOGEIR	IER HOMECARE			GREEN	IWOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN 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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	patient's medical, m	ursing, rehabilitative, social			comprehensive assessments		
	and discharge plann	ning needs The			conducted by RN Clinical		
	Comprehensive Ass	sessment will include a review			Supervisors for a period of 30	days	
	of all medications the	he patient is using			to ensure compliance with the	se	
	(prescription and no	onprescription) Patient			requirements, and to ensure		
	needs are assessed,	and care guidelines			comments such as "see POC"	or	
	established based or	n the assessment data."			"See med profile" are not used	ni t	
					comprehensive assessment		
		cal record of patient #4			documentation. As of 11/10/20	)20,	
	evidenced a start of	care date of 5-12-2020, and			the review of all assessments	has	
	contained a plan of	care for the certification period			revealed 100% compliance. T	he	
		0, with orders for skilled nursing			Director of Clinical Services or	r RN	
		patient with multiple chronic			designee will continue this 100	)%	
	medical conditions.				review for the remainder of the	Э	
					30-day period. After 30 days o	of	
		of care comprehensive			100% compliance, the Directo	r of	
		-12-2020, evidenced patient			Clinical Services or RN desigr	nee	
	_	c health conditions, to include			will review the comprehensive	!	
		a seizure disorder characterized			assessments during the QAPI		
		ataxia [impaired coordination],			quarterly 10% clinical record a	ıudit.	
		nt, behavioral disorder, and			The Director of Clinical Service		
		ler the genitourinary			responsible for monitoring the		
		"History of UTIs [urinary			corrective actions to ensure th		
	_	other reports patient may have			deficiency is corrected and wil	l not	
	1 -	" The comprehensive			recur.		
		document observation of					
	_	or abnormal appearance or					
		of patient #4's genitalia for					
	_	r exudate. Under neurological					
		Specific Seizure Plan:					
	Included in POC [p						
	_	essment failed to document					
		zure plan related to patient #4's					
	1	nder "Additional Respiratory					
	_	lenced "Apnea monitor					
	1 -	plan of care] Cough Assist					
		in Plan of Care." The					
		essment failed to document					
		patient #4's apnea monitor,					
	when it was used, so	ettings, and whether the					

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 32 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	F OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY  COMPLETED  09/18/2020
	ROVIDER OR SUPPLIER		555 E	COUNTY LINE ROAD S NWOOD, IN 46143	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION (X5) SHOULD BE APPROPRIATE COMPLETION DATE
	document any data machine, when it w	al or programmed; and failed to related to patient #4's cough as used, settings, and whether anual or programmed.			
	assessment for rece evidenced under the #4's guardian report time." The compre evidence the location failed to evidence de from patient #4. Un assessment section, tract infections] Mod a yeast infection assessment failed to patient #4's urine for smell, the condition redness, swelling, or assessment "Patient Included in POC [pr comprehensive asses any portion of a sei seizure activity. Un Requirements" evid See med[ication] pr settings: See POC [ Machine: Included comprehensive asses any data related to pr medication(s) which and how often it was document and data monitor, when it was the settings were me failed to document cough machine, who	4's telehealth comprehensive rtification, dated 7-10-2020, e "Pain Assessment" patient red "complains of pain all the hensive assessment failed to on(s) of patient #4's pain, and ocumentation of pain cues rider the genitourinary "History of UTIs [urinary of the reports patient may have of the telephone of the comprehensive of document observation of the patient #4's genitalia for the revidence of the patient #4's genitalia for the p			

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 33 of 84

12/01/2020 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 09/18/2020 15K141 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 555 E COUNTY LINE ROAD SUITE 105 TOGETHER HOMECARE GREENWOOD, IN 46143 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE On 9-16-2020, at 12 noon, the above findings for patient #4 were reviewed with the administrator and the director of clinical services (DOCS) who verified the findings. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review. G 0538 484.55(c)(6)(i,ii) Primary caregiver(s), if any Bldg. 00 The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; G538 G 0538 11/11/2020 Based on record review and interview, the agency Re-educated internal employees failed to ensure a patient had a competent on Admission policy and proper caregiver in the home to provide care, as required documentation of patient's by agency policy, for 1 (Patient 1) of 6 patients informal support system. All whose clinical record was reviewed. clinical records are currently 100% compliant with G 538 and Agency The findings included: policy regarding documentation of a primary caregiver(s), if any, and Review of a policy, "Admission Policy," last other available supports. reviewed/revised 8-21-2019, evidenced, " ... Criteria for Patient Admission ... 7. When Director of Clinical Services or RN determined necessary based on patient's designee will audit 100% of new condition, a competent caregiver and/or family admissions for 60 days to ensure member may assume responsibility for patient care Agency continues to document with intermittent services provided by the agency the primary caregiver(s), if any, and other available supports, as part of each patient's Review of the plan of care for patient #1, comprehensive assessment. After evidenced a start of care date of 7-5-2019, 60 days of 100% compliance,

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

diagnosis of Multiple Myeloma, with a plan of

assessment dated 7-5-2019, evidenced "patient

does not have a primary caregiver able to provide

Review of the patient's comprehensive

care for the certification period of 7-5 to 9-2-2019.

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Director of Clinical Services or RN

quarterly 10% clinical record audit.

designee will monitor continued

compliance during the QAPI

Page 34 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		15K141	B. W	NG		09/18/	/2020
MANGOE	DROVIDED OF CURRY	D.		STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF I	PROVIDER OR SUPPLIE	K		555 E C	COUNTY LINE ROAD SUITE 1	05	
TOGETH	IER HOMECARE			GREEN	WOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the hands-on care (	(sic) he/she requires."			The Director of Clinical Service		
	0:: 0.4.2020 -+.2	15 D.M. dr h £ - 4			and Administrator are respon	sible	
		15 P.M. the above findings were administrator and the director			for monitoring this corrective		
					action to ensure the deficience	y is	
		(DOCS.) The DOCS indicated I's diagnosis and hours of care,			corrected and will not recur.		
	_	qualified caregiver to assume					
		patient #1's care because the					
		nly intermittent home health					
		DOCS verified there was no					
		documented in the clinical					
		ed for additional pertinent					
		nation, or documentation, the					
		DOCS indicated having nothing					
	further to present f						
G 0570	484.60						
		oordination, quality of care					
Bldg. 00		cipation: Care planning,					
		ervices, and quality of care.					
		pted for treatment on the					
		ctation that an HHA can					
	meet the patient's	s medical, nursing,					
	rehabilitative, and	social needs in his or her					
	place of residenc	e. Each patient must					
		lualized written plan of care,					
		isions or additions. The					
	-	n of care must specify the					
		s necessary to meet the					
	l ' '	eeds as identified in the					
		ssessment, including					
		ne responsible discipline(s),					
		ble outcomes that the HHA					
	anticipates will od						
		d coordinating the plan of					
		ualized plan of care must					
		atient and caregiver iining. Services must be					
		rdance with accepted					
	standards of prac						

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 35 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15K141		A. BU	A. BUILDING <u>00</u> COM			SURVEY ETED /2020	
		<u> </u>			ADDRESS, CITY, STATE, ZIP COD	1	-
	PROVIDER OR SUPPLIE	R		555 E C	COUNTY LINE ROAD SUITE 10 IWOOD, IN 46143	05	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DUE OF THE VINCENIE OF T		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	Based on record re failed to maintain of Participation of services, and quality ensure the plan of a aide visits were independent of care; failed to independent of care; failed to independent of baths/shensure the nurse viewere individualized needs (See G 572;) care included a me 574;) failed to ensure valuated and update recertification (See physicians who we patient's care were relation to a patient management plan, of a gastrostomy for the cumulative effects after the provision safe environment of Carticipation of Carticipat	G 586); and failed to ensure re responsible for aspects of a contacted to coordinate care in the need for a seizure care and nutrition requirements and care reding tube (See G 608.)  Sect of these systemic problems are health agency's inability to no fquality health care in a	G 0:		Per ISDH instruction, a response is not recommend for this tag due to the absent of any cited findings.		11/11/2020
G 0572	484.60(a)(1) Plan of care						
Bldg. 00	services that are plan of care that i measurable outco is established, pe signed by a docto	t receive the home health written in an individualized dentifies patient-specific omes and goals, and which riodically reviewed, and or of medicine, osteopathy, within the scope of his or					

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 36 of 84

AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  09/18/2020
	PROVIDER OR SUPPLIEF		555 E (	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 NWOOD, IN 46143	)5
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	If a physician reference care that cannot be evaluation visit, the approve additions original plan.  Based on record responsible to ensure the of care were individed patient's needs for patient and form the plan of care were individed by the patient (Patients #1 and 6) home health aide or patients; failed to endered in the plan patients who receives services; and failed established a minim per week for 1 (Pat received home health and patients.  The findings included the sample of 6 patients.  The findings included the supervision and physician. The plan comprehensive asseptive asseptive asseptive and planting that addresses the comprehensive asseptive and planting that addresses the comprehensive asseptive and provided. The provided the provided to the provided. The provided the provided to the provided		G 0572	G572 All internal employees have be re-educated that each patient individualized frequency and duration is developed in collaboration with the patient and/or family and will be approby the managing Physician. The frequency and duration may ebased on the patient condition informal support status, Physicorder, and patient/family requestant and/or supplemental orders where continue to be utilized to report any deviations from the orders frequency and duration. Agent will make every effort to make any missed visits within the whole week. All clinical records have been reviewed to ensure that ranges are not utilized, and the ranges are kept short/small, and on not vary by more than 1-2 and/or 1-2 hours from the schedule that has been request by the patient and approved be Medicaid. All clinical records a 100% compliant with this requirement.  The Director of Clinical Service.	oved he evolve n or cian est.  e otes rill rt ed cy e up ork e large at at days ested by are

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	l í	JILDING	onstruction 00	(X3) DATE COMPL 09/18/	ETED
	PROVIDER OR SUPPLIER	<b>.</b>		555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 IWOOD, IN 46143	5	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	will be updated as r sixty (60) days T completed in full to duration of visits to and treatments F and education; mea "  2. Review of the clevidenced a start of contained a plan of of 5-12 to 7-10-202 services "Medicaid 1 visit/day X [sic for Medicaid PA [prior (Skilled Nursing) T to schedule these hours/day X 4-6 da Hours (Skilled Nur for Respite hours the schedule on an assection cognitive delay; attraction deficit; sleep related hypoventilation; of epileptic syndromes [feeding tube] status nursing visit notes were consistently 8 care ordered on the hour range from 6.5 wide of a variation individualized to m  On 9-8-2020 at 2:0 minor patient #4, whours for the skilled to stay 8-10 hours to	R LSC IDENTIFYING INFORMATION necessary, but at least every the Plan of Care shall be of include: Frequency and of me made All medications ratient-specific interventions surable outcomes and goals  Initical record for patient #4, Care date of 5-12-2020, and Care for the certification period 10, with orders for skilled nursing State Frequency and Duration or] 4-6 days/week for 9 weeks; cauthorization] Program Hours the patient's mother has chosen ours as follows 6.5 - 10.5 ys/week Medicaid Respite sing) The patient is authorized that the patient's mother will needed basis." The plan of gnoses of Dravet Syndrome of developmental delay; ention and concentration d non-obstructive alveolar ther generalized epilepsy and so obesity; and gastrostomy so. Review of the skilled evidenced the nurse visits to 10 hours to provide the plan of care. The nurse visit to 10.5 hours per visit was too for care orders and was not eet the patient's needs.  1 P.M., the parent guardian of then queried about plan of care d nurse, stated the nurses had to provide all the care patient		TAG	RN designee will audit 100% of outgoing plans of care for 30 of to ensure that each patient's nursing or home health aide frequency and duration remain compliant with this requirement and to ensure that no large rare are utilized. Once 100% compliance has been maintain for 30 days, the Director of Clin Services or RN designee will continue to include evaluation the frequency and duration an adherence to the ordered frequency and duration as parthe 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 visital RN Clinical Supervisors has been re-educated on the care planning process for home heat aide tasks, including the establishment of a minimum weekly bath/shower schedule patients with baths/showers or their aide care plan. The issue was immediately corrected whe all Agency aide care plans we audited by the Director of Clini Services to ensure the presental minimum weekly bathing threshold when applicable. All care plans are currently 100% compliant.  In order to ensure a deficient	of days  as att, ages  and anical of d  at of tof  atth  for a control of total oce of aide	DATE
	#4 required. When	queried whether guardian had			practice does not occur, the		

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 38 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		15K141	B. W	ING		09/18/	2020
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD	\ <i>E</i>	
TOCETI					COUNTY LINE ROAD SUITE 10	13	
IUGEIF	IER HOMECARE			GREEN	IWOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN 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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	chosen to schedule	the skilled nursing care hours			Director of Clinical Services w	ill	
	on a range of 6.5 to	10.5 hours, the guardian			audit 100% of new Aide Care		
	stated wanting all th	ne hours patient #4 was			Plans for 30 days to ensure 10	00%	
	allowed, to include respite care. The guardian of patient #4 stated the agency had never provided				compliance with establishing a		
					minimum number of		
	respite care hours d	ue to lack of staffing.			baths/showers per week to be	,	
					provided to the patient by the		
	3. Review of the cl	inical record for patient #1,			home health aide for patients	with	
	evidenced a start of	care of 7-5-19, and contained			baths/showers on their care pl	an.	
	a plan of care for th	e certification period of 7-5 to			After 30 days of 100%		
	9-2-2019, with orde	ers for home health aide (HHA)			compliance, the Director or RN	١	
	"Medicaid State Fro	equency and Duration: 1			designee will include review o	f	
	visit/day X 6-7 day	s/week for 9 weeks Medicaid			Aide Care Plans during the 10	%	
	PA [sic prior author	rization] Program Hours: The			quarterly record audit to ensur	·e	
	patient has chosen t	to schedule PA hours as			compliance is maintained.		
	follows: 1-5 hours/o	day X 3-5 days/week, 2-6 hours			The Administrator and Directo	r of	
	a day X 1-2 days/w	eek, 0.5- 4 hours/day X 1-3			Clinical Services are responsil	ble	
	days/week Medic	caid Waiver Program Hours:			for monitoring the corrective		
	The patient has cho	sen to schedule Waiver hours			actions to ensure the deficience	су	
	as follows: 3-7 hou	rs/day X 3-5 days/week, 2-6			will not recur.		
	hours/day X 1-2 day	ys/week, 4-8 hours/day X 1-3					
	-	rimary diagnosis was Multiple					
	Myeloma. Function	nal limitations listed included					
	"endurance."						
	_	zation hour duties enumerated					
	-	included: Bathing: Shower					
		sed during bathing; assist with					
		iene and Grooming: Assist with					
	_	sist with Nail Care PRN; Assist					
	_	I; Hair Care PRN; Peri Care					
		of shower/bath was ordered					
	PRN [as needed] w	ith no minimum shower/bath					
	per week establishe	d.					
	•	1 start of care comprehensive					
		-5-2019, evidenced "Patient					
		mary caregiver able to provide					
		e/she requires." Height of 5'					
	1	0 pounds was documented.					
	Patient #1 reported						

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  09/18/2020
	PROVIDER OR SUPPLIEI HER HOMECARE	₹	555 E (	ADDRESS, CITY, STATE, ZIP CO COUNTY LINE ROAD SU NWOOD, IN 46143	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
	on 7-16-2019. For bowel incontinence wears incontinence wears incontinence Durable medical educices of cane [rat walker-used post-op post-op, right foot braces to used as not chair/bench. Patien "Moderate Assist w living.]  Review of the HHA evidenced "Visit Frace X 6-7 days/week."  The documented so [Saturday] PA [prical P; W [Waiver] 12 Handle 12 Handle 14 Handle 14 Handle 15 Handl	gastrointestinal "will experience if he/she is very sick and products PRN [as needed.] quipment included assistive rely used,] walker Knee p, Manual wheelchair, used brace, bilateral wrist/hand reded, and shower at Independence was with ADLs [activities of daily  A care plan dated 7-5-2019, requency/Duration: 1 visit /day  hedule was "M [Monday]-Sat or authorization] = 9 AM to 12  PM to 5 PM Sun [Sunday] PA  W = 11 AM to 5 PM." The 30  s on the HHA care plan did			

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 40 of 84

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/18/	ETED
	PROVIDER OR SUPPLIER	2	•	555 E C	DDRESS, CITY, STATE, ZIP COD OUNTY LINE ROAD SUITE 10 WOOD, IN 46143	5	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
ING	HHA visits were m	ost often 3 hours for PA, and er. The clinical director verified		IAG			DATE
	which zero shower/	of the certification period for bath had been documented.					
	for patient #1, the c	the HHAs were in the home linical director said for hygiene					
	had been establishe	queried why no hygiene goal d individualized to include a of showers/baths per week, the					
	clinical director sta	ted believing "as needed" was deried why the HHA visit					
	orders had large rar 2-6 hours a day						
	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  ed what the HHA could					
	accomplish in a 0.5 indicated, "I don't k	hour visit, the clinical director now." When asked what					
	hour visit, a 2 hour	and 6 hour visit, or a 0.5 hour					
	identified in the cor	it, based on patient's #1 needs in prehensive assessment, the in o explanation. The clinical					
	manager verified pa	atient #1 did not have a in the home to assist with					
	which affected amb	#1 had recent foot surgery bulation and mobility. The sure the HHA care visit orders					
	were individualized which would meet	to a narrow range of hours patient #1's needs as identified					
	in the comprehension  4. Review of the cl	ve assessment. inical record of patient #6					
	evidenced a start of contained a plan of of 8-17 to 10-15-20	care date of 8-17-2020, and care for the certification period 20, with orders for HHA care					
		ate Frequency and Duration: 1 s/ week X 9 weeks; Medicaid					

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 41 of 84

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY  COMPLETED  09/18/2020			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  555 E COUNTY LINE ROAD SUITE 105  GREENWOOD, IN 46143					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION			
	wife have chosen to authorization] hour X 1-3 days/ week, a week Medicaid Wa The patient and his his Waiver hours as 4-6 days/week." Pa documented as Mulevidenced wheelchard thoyer lift for transfor PA were Assist medical equipment notify Clinical Supudisrepair or require wheelchair every viambulation/transfer be used for ALL pa or Stander] Show during bathing, assist medical patient assist with laundry every visit, vacuum weekly and PRN and PRN, Assist with a PRN, Assist food into small bite visit Notify Clinical Serve Meals Every Precautions, Assist food into small bite visit Notify Clinical PRN, Assist Patient #6 was identification of care even worked outside hor provide necessary of the plan of care even worked outside hor provide necessary of the plan of care even worked outside hor provide necessary of the plan of care even worked outside hor provide necessary of the plan of care even worked outside hor provide necessary of the plan of care even worked outside hor provide necessary of the plan of care even worked outside hor provide necessary of the plan of care even worked outside hor provide necessary of the plan of care even worked outside hor provide necessary of the plan of the p	(HHA) The patient and his o schedule his PA [prior is as follows: 0.5 to 4 hours/day and 5-9 hours/day X 4-6 days/ after Program Hours (HHA) wife have chosen to schedule is follows: 0.5 - 4.5 hours/ day X attent #6 primary diagnosis was attiple Dystrophy, and hair dependence and use of the certain to keep DME [durable after Assistive Devices clean, and the ervisor if any items are in attention assist with the severy visit, Hoyer lift must tient transfers [use Hoyer lift were chair/bench to be used st with shower (Tuesday ge bed linens weekly and PRN Housekeeping every visit, weekly assist with dishes assist with Shampoo weekly the Dressing Every visit, Peri Handling/ Bringing meds [sic tent (No administering,) Verbal ders Every visit Prepare/visit, Follow Aspiration with feeding, to include cut is PRN, Encourage Fluids Every cal Supervisor if no BM in 3 the BM date PRN, Change brief/set to Commode Every Visit. Itified as a high risk for falls. Itidenced patient #6's wife the full time and was unable to the are during working hours. Ited to individualize the HHA						

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 42 of 84

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIP A. BUILDIN B. WING		NSTRUCTION  00	(X3) DATE COMPI 09/18	LETED
	PROVIDER OR SUPPLIER		55	5 E C	OUNTY LINE ROAD SUITE	105	
TOGETH	IER HOMECARE		GF	KEEN	WOOD, IN 46143		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	for a visit, and faile plan orders to range rationally related to assistance with ADI when wife was at full 5. On 9-18-2020, a the director of clinic the above findings, believed the ranges attending physician orders. When asked information, explan administrator and D June 17, 2019, from home and hospice or range of 1-7 days for much of a variable, justify hours of care hours of variation a justification for the a caregiver, or other	t 4 P.M., the administrator and cal services (DOCS) verified and stated the agency were proper because the had signed the plan of care d for additional pertinent ation, or documentation, the POCS provided an email from a the director of an Indiana are association which stated a per care visits per week, was too and relied on this email to be per visit ranges having 3-4 s permissible, without range based on availability of repertinent factors.					
G 0574	410 IAC 17-13-1 (a						
		include the following					
Bldg. 00	The individualized the following: (i) All pertinent dia (ii) The patient's m cognitive status; (iii) The types of s equipment require (iv) The frequency made; (v) Prognosis; (vi) Rehabilitation	plan of care must include gnoses; nental, psychosocial, and ervices, supplies, and ed; and duration of visits to be potential;					
	(vi) Rehabilitation (vii) Functional lim						

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 43 of 84

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		15K141	B. W	ING		09/18	/2020
		<b>.</b>		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹			COUNTY LINE ROAD SUITE 10	15	
TOGETH	HER HOMECARE				IWOOD, IN 46143	13	
TOGETT	IERTIONECARE			GINEEN	1000B, IN 40143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(viii) Activities permitted;						
	(ix) Nutritional req	uirements;					
	(x) All medications and treatments;						
	(xi) Safety measu	res to protect against					
	injury;						
	(xii) A description	of the patient's risk for					
	emergency depar	tment visits and hospital					
	re-admission, and	I all necessary interventions					
	to address the un	derlying risk factors.					
	(xiii) Patient and o	caregiver education and					
	training to facilitat	e timely discharge;					
	(xiv) Patient-spec	ific interventions and					
	education; measu	rable outcomes and goals					
	identified by the H	IHA and the patient;					
	(xv) Information re	elated to any advanced					
	directives; and						
	(xvi) Any addition	al items the HHA or					
	physician may ch	oose to include.					
			G 0	574			11/11/2020
		view and interview, the agency			G574		
		plan of care included a			All RN Clinical Supervisors ha	ve	
	1	e goal for 1 (Patient #1) of 4			been re-educated on the care		
	_	red home health aide services			planning process for home he	alth	
	only, out of a samp	le of 6 patients.			aide tasks and the establishm	ent	
					of patient goals that are specif		
	The findings include	led:			and measurable, including the	<b>;</b>	
					establishment of a minimum		
		, "Home care services are			weekly bath/shower hygiene g		
		supervision and direction of			for patients for whom bathing		
		ian. The plan of care is based			the aide care plan. The issue		
	_	e assessment and information			immediately corrected when a	II	
		ient/family and health team			Agency aide care plans were		
		g for care is a dynamic process			immediately audited by the		
	that addresses the care, treatment and services to				Director of Clinical Services to		
		plan will be consistently			ensure the presence of a mini		
		that patient needs are met, and			weekly hygiene goal related to		
	_	necessary, but at least every			bathing when applicable. All a		
		The Plan of Care shall be			care plans are currently 100%		
		include: Frequency and			compliant.		
	duration of visits to	me made All medications			In order to ensure a deficient		

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 44 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL		
		15K141	B. W	ING		09/18/	/2020	
NAME OF T	DOMDED OF CURRY		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
NAME OF P	PROVIDER OR SUPPLIEF	C		555 E C	COUNTY LINE ROAD SUITE 10	5		
TOGETH	ER HOMECARE			GREENWOOD, IN 46143				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		Patient-specific interventions			practice does not occur, the			
	and education; mea	surable outcomes and goals			Director of Clinical Services or			
	"				designee will audit 100% of ne			
	TD 1 C.1 11 1	1.0			Aide Care Plans for 30 days to			
	Review of the clinical record for patient #1, evidenced a start of care of 7-5-19, and contained				ensure 100% compliance with			
					establishing a minimum/goal			
	-	e certification period of 7-5 to			number of baths/showers per			
		ers for home health aide (HHA)			week to be provided to the pat	uent		
		equency and Duration: 1 s/week for 9 weeks Medicaid			by the home health aide for	2		
		rization] Program Hours: The			patients with baths/showers or			
		so schedule PA hours as			their care plan. After 30 days of 100% compliance, the Directo			
	-	day X 3-5 days/week, 2-6 hours			RN designee will include revie			
		eek, 0.5- 4 hours/day X 1-3			Aide Care Plans during the 10			
		caid Waiver Program Hours:			quarterly record audit to ensur			
	-	sen to schedule Waiver hours			compliance is maintained.	C		
	-	rs/day X 3-5 days/week, 2-6			The Administrator and Directo	r of		
		ys/week, 4-8 hours/day X 1-3			Clinical Services are responsil			
		rimary diagnosis was Multiple			for monitoring the corrective a			
		nal limitations listed included			to ensure the deficiency will no			
	"endurance."				recur.			
	HHA prior authoriz	zation hour duties enumerated						
	on the plan of care	included: Bathing: Shower						
	chair/bench to be us	sed during bathing; assist with						
	Shower: PRN; Hyg	iene and Grooming: Assist with						
	-	sist with Nail Care PRN; Assist						
		I; Hair Care PRN; Peri Care						
		of shower/bath was ordered	1				1	
		ith no minimum shower/bath						
	*	d. The plan of care failed to						
		elation to hygiene for patient						
		IHA services only, ordered 5-7						
	days per week.							
		sit notes for the certification						
	period evidenced the HHA was in patient #1's							
		s were 7 days/week, except for						
	missed visits.							
	On 9-8-2020 at 1:	15 P.M. the above findings were						

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

Event ID:

ZP5711

Facility ID: 013867

867

If continuation sheet Page 45 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			TED
		15K141	B. WI	NG	_	09/18/2	2020
	PROVIDER OR SUPPLIER		•	555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 NWOOD, IN 46143	)5	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
G 0586	clinical services (DO minimum number of been established for DOCS had no explat further pertinent explation, the	)(1)(C)					
0000	· '	on of the plan of care					
Bldg. 00	Standard: Review	and revision of the plan of					
	care.		$  _{\mathbf{G}}$	506			11/24/2020
	Based on record rev registered nurse fail was evaluated and u recertification for 2 patients on service in The findings included 1. Review of a politic reviewed/revised 8-stated, "Home care the supervision and physician. The plan comprehensive asseprovided by the patient members. Planning that addresses the case be provided. The previewed to ensure will be updated as in the state of the supervision and physician.	·	G 0.	586	G586 All internal employees have be re-educated that each patient individualized frequency and duration is developed in collaboration with the patient and/or family and will be approby the managing Physician. To frequency and duration may estated on the patient condition informal support status, Physician order, and patient/family requested accordingly in the clinical record. Missed visit not and/or supplemental orders we continue to be utilized to reposany deviations from the ordered frequency and duration. Agen will make every effort to make	een oved he evolve n or cian est. e otes iill rt ed cy	11/24/2020

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 46 of 84

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K141	B. WI	NG		09/18/	/2020
				_			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD	_	
					COUNTY LINE ROAD SUITE 10	5	
TOGETH	HER HOMECARE			GREEN	IWOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWING DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	completed in full to	include: Frequency and			week. All clinical records have		
	^	me made All medications			been reviewed to ensure that	arge	
	and treatments F	Patient-specific interventions			ranges are not utilized, and the	Ū	
	and education; measurable outcomes and goals				ranges are kept short/small, a		
	"	Č			do not vary by more than 1-2 o		
	2. Review of the clinical record for patient #1, evidenced a start of care of 7-5-19, and contained				and/or 1-2 hours from the	,	
					schedule that has been reque	sted	
					by the patient and approved by		
		e certification period of 9-3 to			Medicaid. All clinical records a	-	
	^	ders for home health aide (HHA)			100% compliant with this		
		equency and Duration: 1			requirement.		
		s/week for 9 weeks Medicaid			Toquironiana		
		rization] Program Hours: The					
		to schedule PA hours as			The Director of Clinical Service	es or	
	^	day X 3-5 days/week, 2-6 hours			RN designee will audit 100% of		
		eek, 0.5- 4 hours/day X 1-3			outgoing plans of care for 30 c		
	1	caid Waiver Program Hours:			to ensure that each patient's	ays	
	· ·	sen to schedule Waiver hours			nursing or home health aide		
	-	rs/day X 3-5 days/week, 2-6			frequency and duration remain	ne	
		ys/week, 4-8 hours/day X 1-3			compliant with the requiremen		
		rimary diagnosis was Multiple			and to ensure that no large rai		
		nal limitations documented			are utilized. Once 100%	iges	
		e." HHA prior authorization			compliance has been maintair	had	
		ated on the plan of care			for 30 days, the Director of Cli		
		ng: Shower chair/bench to be			Services or RN designee will	ilicai	
		g; assist with Shower: PRN;			continue to include evaluation	of	
		ning: Assist with Shampoo			the frequency and duration an		
		Iail Care PRN; Assist with			adherence to the ordered	u	
	·	ir Care PRN; Peri Care PRN.			frequency and duration as par	t of	
	_	ower/bath was ordered PRN			the Agency's quarterly QAPI 1		
		minimum shower/bath per			clinical record audit to ensure	J /U	
		Review of the comprehensive			continued compliance.		
		-28-19, evidenced patient #1			All RN Clinical Supervisors ha	VA.	
		chronic pain; and occasional			been re-educated on the	٧ <del>८</del>	
	incontinence of bla	-					
	incommence of bla	dder and bower.			re-certification process as a	oro	
	Davious of the 60 1	ou summany of the along of some			method for re-evaluating the c		
		ay summary of the plan of care			planning process for home her		
		period of 9-3 to 11-1-19,			aide tasks that are specific to	ıne	
	_	1 had co-morbidities of			patient's changing needs and		
	chronic pain, asthm	a, difficulty walking,	1		abilities, as identified by the		1

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 47 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		15K141	B. W	ING		09/18/2020	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			COUNTY LINE ROAD SUITE 10	5	
TOGETH	IER HOMECARE				NWOOD, IN 46143	O	
100211	IERTIONIEO/IRE			OINELI	, III 40140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLET	ION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENC!)	DATE	
	_	tis, systemic involvement of			patient and Agency. All aide c	are	
		najor depressive disorder,			plans for active patients were		
		gue, and hypothyroidism (low			immediately audited by the		
	function of the thyroid gland) "continues to				Director of Clinical Services to		
	require significant assistance in her home with				ensure the presence of a mini		
	ADLs (activities of daily living)/ IADLs				weekly bathing threshold whe		
	1	ties of daily living) as well as			applicable. All aide care plans	are	
		sportation/errand on her			currently 100% compliant. All		
		The registered nurse failed to			internal clinicians have been		
	_	f care to ensure a minimum			re-educated on ensuring that		
	1	lower/bath was care planned			patient's frequency and durati	on is	
	-	's assessed needs and			individualized and must be		
	functional limitation	ns.			re-evaluated regularly, includi	-	
					the re-certification assessmen	t.	
		linical record for patient #4,			All clinical records were		
		f care date of 5-12-2020, and			immediately reviewed to valid		
	_	care for the certification period			that the visit hours established		
		), with orders for skilled nursing			the plan of care for nurses and	1	
		State Frequency and Duration			home health aides are		
		or] 4-6 days/week for 9 weeks;			individualized, based on meet	-	
		authorization] Program Hours			the identified needs of the pat		
	·	The patient's mother has chosen			The Director of Clinical Servic		
		ours as follows 6.5 - 10.5			RN designee will audit 100%		
		ys/week Medicaid Respite			new Aide Care Plans and Plan	is of	
		sing) The patient is authorized			Care for 30 days to ensure		
	^	nat the patient's mother will			continued 100% compliance v	rith	
		needed basis." The plan of			individualized frequency and		
		gnoses of Dravet Syndrome			duration and establishment of	a	
		of developmental delay;			minimum number of		
		ention and concentration			baths/showers per week for	N :	
		d non-obstructive alveolar			patients who have bathing on		
		her generalized epilepsy and			care plans. The Director of Cli		
		s; obesity; and gastrostomy			Services or RN designee will a	luult	
		s. The skilled nurse had			100% of start of careand re-certification assessments for	.r 20	
		r medications through the					
	gastrostomy tube.				days to ensure the aide care p		
	Davious of the man	OASIS (Outcome and			continues to reflect the patient		
		OASIS (Outcome and			current needs. After 30 days of		
		ation Set) comprehensive			100% compliance, the Directo		
	assessment dated 7	-10-2020, evidenced patient #4			RN designee will include revie	w of	

ZP5711

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15K141	B. W	ING		09/18/2020	
		<u> </u>	1	CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ROUNTY LINE ROAD SUITE 10	15	
TOGETH	IER HOMECARE				IWOOD, IN 46143	10	
IOGETH	IEN HUIVIEUARE			GREEN	1000D, IN 40143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	complained of "pain all the			frequency and duration and Ai	ide	
		; and was dependent on			Care Plans during the quarter	-	
	1 -	ng, dressing, and stand by			QAPI 10% clinical record audi	t to	
	assist for ambulatio	n.			ensure compliance is maintair	ned.	
					The Administrator and Directo		
		e visit notes from the previous			Clinical Services are responsil		
		evidenced the skilled nursing			for monitoring the corrective a		
		urs consistently to meet patient			to ensure the deficiency will no	ot	
		le parent guardian was at work.			recur.		
		r range from 6.5 to 10.5 hours					
	1 ^	de of a variation for care					
	orders and was not individualized to meet the						
	*	ecause the agency had data					
		evidencing care entailed visits					
	of 8-10 hours per vi	ısıt.					
	4 0:: 0 0 2020 -+/	2.01 D.M. 4b					
		2:01 P.M., the parent guardian of					
	_	then queried about plan of care distributed about plan of care distributed about plan of care					
		o provide all the care patient					
		queried whether guardian had					
	_	the skilled nursing care hours					
		10.5 hours, the guardian					
	_	he hours patient #4 was					
	_	respite care. The guardian of					
		e agency had never provided					
	_	ue to lack of staffing.					
	5. On 9-18-2020. a	at 4 P.M., the administrator and					
		cal services (DOCS) verified					
		and stated the agency					
	I -	were proper and did not need					
	_	ise the attending physicians					
		of care orders. When asked					
		nent information, explanation,					
	_	the administrator and DOCS					
		From June 17, 2019, from the					
	l ~	(Indiana Association for Home					
		which stated a range of 1-7					
		per week, was too much of a					

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 49 of 84

STATEMEN		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15K141	B. WI	NG		09/18/2020	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 555 E COUNTY LINE ROAD SUITE 105 GREENWOOD, IN 46143				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWINED'S BLANGE 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)	16	DATE
	of care per visit rang variation as permiss						
G 0608	484.60(d)(4) Coordinate care d	- II					
Bldg. 00	Coordinate care deneeds, and involve (if any), and carego the coordination of Based on record reversalled to ensure physical for aspects of a patic coordinate care in reseizure care and marrequirements and catube, for 1 (Patient # nursing care, out of The findings included Review of a policy, reviewed/revised 8-Care is based on a cand information proand health team merconsistently reviewed needs are met "  Review of the clinical evidenced a start of contained a plan of the coordinate of th	elivery to meet the patient's ethe patient, representative iver(s), as appropriate, in f care activities.  The wand interview, the agency sicians who were responsible ent's care were contacted to elation to a patient's need for a magement plan, nutrition are of a gastrostomy feeding (44) of 2 patients with skilled a sample of 6 patients.  The Plan of Care," last 21-19, evidenced, "The Plan of comprehensive assessment vided by the patient/family mbers The plan will be ed to ensure that patient  all record for patient #4, care date of 5-12-2020, and care for the certification period	G 0)	608	G 608 Patient #4's seizure plan was updated in September with patient's re-certification. Direct of Clinical Services audited cu Plan of Care for 100% of Ager patients with seizure diagnosis ensure patient-specific seizure plans were present, with additi orders sent to the Physician as required. All records are 100% compliant. All Agency RN Clini Supervisors have been re-educated on the importance coordinating care with other managing physicians when applicable, to ensure comprehensive oversight of th patient's care plan. Agency will continue to contact relevant physicians for specialty areas	rrent ncy s to s ional s ical e of	10/21/2020
	_	0, with orders for skilled nursing			patient care when so directed the Physician signing the hom- health plan of care.	by	

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 50 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15K141 09/18/2020 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 555 E COUNTY LINE ROAD SUITE 105 TOGETHER HOMECARE GREENWOOD, IN 46143 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Review of the start of care comprehensive The Director of Clinical Services or assessment, dated 5-12-2020, evidenced patient RN designee will audit 100% of had multiple chronic health conditions, to include outgoing plans of care for 30 days Dravet Syndrome [a seizure disorder characterized to ensure plans of care are by frequent seizure, ataxia [impaired coordination], compliant. Following 30 days of cognitive impairment, behavioral disorder, and 100% compliance, the Director of motor deficits. The comprehensive assessment Clinical Services or RN designee documented patient #4 had a gastrostomy tube will evaluate this component for tube feedings and water intake into the during the Agency's quarterly 10% stomach. Under neurological assessment "Patient clinical record audit to ensure Specific Seizure Plan: Included in POC [plan of continued compliance. care.]" The comprehensive assessment failed to The Director of Clinical Services is document a seizure plan related to the care and responsible for monitoring this management of patient #4's seizure activity. corrective action to ensure the Review of the plan of care failed to evidence a deficiency is corrected and will not seizure care and management plan for patient #4. Completed 10/21/20 and ongoing Review of the recertification comprehensive assessment dated 7-10-2020, evidenced under neurological assessment "Patient Specific Seizure Plan: Included in POC [plan of care.]" Review of the plan of care failed to evidence a plan for the care and management of patient #4's seizure activity. Review of the comprehensive assessment and the plan of care failed to evidence a seizure care and management plan for patient #4. Review of the clinical record, to include the plans of care, physician orders, and patient log entries, failed to evidence the agency had determined the name and contact information for patient #4's neurologist and gastroenterologist, to coordinate care in relation to a seizure care and management plan. On 9-14-2020 at 2:00 P.M., during telephone call with patient #4's attending physician's office (person CC) to review patient #4's plan of care, the nurse stated the attending physician did not manage patient #4's seizure medication or seizure

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 51 of 84

PRINTED: 12/01/2020 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	9
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00  B. WING			(X3) DATE SURVEY COMPLETED 09/18/2020		
	PROVIDER OR SUPPLIER	2	555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 1 IWOOD, IN 46143	05	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE CONTESTIC	ON
TAG	plan and did not ma care,maintenance, a	anage enteral feedings, and changing of patient #4's r the enteral and hydration	TAG	DEFICIENCY)	DATE	
	verified by the adm clinical services (Do agency nurse and Do neurologist and gas the DOCS indicated attending physician pertinent information documentation, the	200 P.M., the above findings were inistrator and the director of OCS.) When queried why the OCS had not contacted the troenterologist for patient #4, I having dealt only with the . When queried for additional on, explanation, or administrator and DOCS thing further to present for				
	410 IAC 17-14-1 (a 410 IAC 17-12-2 (g 410 IAC 17-14-1 (a	(;)				
G 0640 Bldg. 00	484.65 Quality assessme improvement Condition of partic assessment and p (QAPI).					
	and maintain an elementario en eleme	velop, implement, evaluate, ffective, ongoing, riven QAPI program. The body must ensure that the he complexity of its services; involves all HHA g those services provided arrangement); focuses on to improved outcomes, of emergent care services, hs and re-admissions; and				

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

takes actions that address the HHA's

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 52 of 84

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  09/18/2020		
	PROVIDER OR SUPPLIER	₹		555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE IWOOD, IN 46143	105	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	:	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	on Be PRIATE	(X5) COMPLETION DATE
	including the prevented medical errors. The documentary evide and be able to de CMS.  Based on record recor	ss the spectrum of care, ention and reduction of the HHA must maintain dence of its QAPI program monstrate its operation to the entity of the condition of the entity of t	G 06	540	Per ISDH instruction, a response is not recomme for this tag due to the abs of any cited findings.		11/11/2020

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 53 of 84

12/01/2020 PRINTED: FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/18/2020
	PROVIDER OR SUPPLIEF		555 E	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 NWOOD, IN 46143	05
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF resulted in the home	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION e health agency's inability to n of quality health care in a	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
G 0642 Bldg. 00	safe environment for Participation of  484.65(a)(1),(2) Program scope Standard: Program (1) The program reshowing measural indicators for which improvement in the health outcomes, of care.  (2) The HHA must track quality indicated patient events, and performance that processes of care operations.  Based on record reversible to implement have identified mean health aide miscond both areas which woutcomes, and qual reviewed, the 2020		G 0642	G 642 The Administrator and Director Clinical Services have been re-educated on the Agency's QAPI program, including reviet the Agency's Performance Improvement Policy. The Director Clinical Services completed HHQI's QAPI course, "Pave you Path," for additional QAPI education and guidance.	ew of ctor
	undated, evidenced To design processes	"Performance Improvement," the policy stated, " Purpose s, which through collaboration disciplines, will meet the needs		Beginning with the Agency's 3 quarter QAPI report, which de all findings from the Agency's QAPI review, including the clir record audit results and measurement, analysis and	tails

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

of patients, staff and the community. To identify

areas for improvement in the quality of care,

Event ID:

ZP5711

Facility ID: 013867

tracking of data for falls,

complaints, adverse events,

If continuation sheet

Page 54 of 84

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		15K141	B. WING		09/18/2020
	PROVIDER OR SUPPLIED	R	STREET ADDRESS, CITY, STATE, ZIP COD 555 E COUNTY LINE ROAD SUITE 105 GREENWOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	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	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		ces. To improve patient and		infections, hospitalizations / E	
		rough a coordinated		visits, as well as any required	``
	1 -	each to assessing and		performance improvement pla	nns
		ational performance. To		the Director of Clinical Service	
		f concern and implement plans		and Administrator will review	
	to resolve the issue			Agency's quarterly report aga	
	to reserve the issue			the Agency's Performance	iiiot
	Review on 9-17 and	d 9-18-2020, of the QAPI log for		Improvement Policy to ensure	the
		complaints of HHA misconduct		QAPI report contains the	, tillo
		f missed care visits.		identification, implementation,	and
	and reomplaines o	i missed care visits.		adherence to performance	and
	On 9-18-2020 at 1	2 noon, the 2020 QAPI program		improvement plans. This valid	lation
		vas reviewed with the		of compliance will continue	lation
		he director of clinical services		quarterly to ensure compliance	e is
		complaints in the 2020		maintained. Conformance of t	
		ed to the agency policy and		Agency's QAPI efforts to the	
		to home health aide (HHA)		Performance Improvement Po	alicy
	_	mplaints of missed visits. The		will be reported to the Govern	-
		re was a pattern of complaints		Body during quarterly QAPI	"'9
		sconduct and missed care		reviews to ensure the deficier	ncv
		d the QAPI program did not		does not recur.	loy
		e 2 areas, had not captured a		The Director of Clinical Service	200
		onduct and missed care visits,		and Administrator are respons	
		ram was unable to show		for monitoring the corrective	SIDIC
		ement in these areas or the		actions to ensure the deficien	rv is
		any performance improvement		corrected and will not recur.	
		ied if meeting the visits ordered		Corrected and will not recar.	
		and HHA misconduct were			
		measures, the DOCS response			
		asked for additional pertinent			
		nation, or documentation, the			
	_	OOCS indicated having nothing			
	further to present for				
	I   I   I   I   I   I   I   I   I   I	·- <del>-</del> · · ·			
	410 IAC 17 12 2 /	.)			
	410 IAC 17-12-2 (a	1)			
G 0644	484.65(b)(1),(2),(3	3)			
	Program data				

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

Standard: Program data.

Bldg. 00

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 55 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			· '	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00 COMPLETED	
		15K141	B. W	ING		09/18/2020
NAME OF I	PROVIDER OR SUPPLIEF	<b>.</b>			ADDRESS, CITY, STATE, ZIP COD	_
TOOFT	IED HOMEOADE				COUNTY LINE ROAD SUITE 10	05
TOGETH	IER HOMECARE			GREEN	NWOOD, IN 46143	
(X4) ID		STATEMENT OF DEFICIENCIE		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	i	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY	DATE
		nust utilize quality indicator easures derived from				
	_	plicable, and other relevant				
	data, in the design					
	]	1 3				
		t use the data collected to-				
		ectiveness and safety of				
	services and qual					
	(ii) Identify opport	unities for improvement.				
	(3) The frequency	and detail of the data				
(3) The frequency and detail of the data collection must be approved by the HHA's						
governing body.						
	9		G 0	644	G 644	11/11/2020
	Based on record rev	view and interview, the agency			The Agency's Performance	
	failed to implement	its policy which required it to			Improvement Policy, B-260, h	as
		rived from OASIS (Outcome			been modified to reflect that	
		Formation Set) in order to			OASIS data may be utilized a	s an
		veness and safety of services			evaluation tool for agency	
		in the design of 1 of 1 year			performance. The Agency will	
		quality assessment and vement (QAPI) program.			utilize quality indicator data, including measures derived fr	om
	performance impro	venient (QAI I) program.			OASIS, where applicable, in it	
	The findings includ	led:			QAPI Program to monitor the	
					effectiveness and safety of	
	Review of a policy,	"Performance Improvement,"			services and quality of care, a	ind
		the policy stated, " The			to identify opportunities for	
		ce improvement program			improvement, in accordance v	vith
		ot limited to, the following:			the Medicaid regulation.	
		QI (Outcome Based Quality			Administrator and Director of	
		OBQM (Outcome Based ) data from OASIS submission			Clinical Services have been	
	documents "	g data from OASIS submission			educated on the Agency's  Performance Improvement po	dicy
	assuments				The Administrator and Director	•
	On 9-17 and 9-18, 2	2020, the data in the 2020 QAPI			Clinical Services will validate	
		d and failed to evidence			quarterly QAPI report to ensu	re
	indicators derived f	from OASIS.			that measures derived from	
				OASIS, where applicable, are		
		2 noon, the QAPI data was			incorporated into the report to	
	reviewed with the a	dministrator and the director of			ensure ongoing compliance.	

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 56 of 84

TAG REGULATORY OR LSC IDENTIFYING INFORMATION  clinical services (DOCS.) When queried if the agency had submitted OASIS data for skilled care patients, the DOCS replied "Yes." When queried if the QAPI program included any measures derived from OBQI and OBQM, the DOCS indicated not knowing what those terms meant after the names of the acronyms were provided. When queried if the QAPI program included any measures derived from OASIS reports, the DOCS replied "No." The administrator and the DOCS indicated not having implemented their policy as written. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing	(X3) DATE SURVEY COMPLETED 09/18/2020	ONSTRUCTION  00	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		IT OF DEFICIENCIES OF CORRECTION	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG (CROSS-REFRENCED TO THE APPROPRIATE DATE)  clinical services (DOCS.) When queried if the agency had submitted OASIS data for skilled care patients, the DOCS replied "Yes." When queried if the QAPI program included any measures derived from OBQI and OBQM, the DOCS indicated not knowing what those terms meant after the names of the acronyms were provided. When queried if the QAPI program included any measures derived from OASIS reports, the DOCS replied "No." The administrator and the DOCS indicated not having implemented their policy as written. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing  COMPLETIC REACHCORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DATE  TAG  The Director of Clinical Services and Administrator are responsible for monitoring the corrective action to ensure the deficiency is corrected and will not recur.		COUNTY LINE ROAD SUITE 10	555 E (			
agency had submitted OASIS data for skilled care patients, the DOCS replied "Yes." When queried if the QAPI program included any measures derived from OBQI and OBQM, the DOCS indicated not knowing what those terms meant after the names of the acronyms were provided. When queried if the QAPI program included any measures derived from OASIS reports, the DOCS replied "No." The administrator and the DOCS indicated not having implemented their policy as written. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing	ULD BE COMPLETION PROPRIATE	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	PREFIX	CY MUST BE PRECEDED BY FULL	(EACH DEFICIEN	PREFIX
G 0648  484.65(c)(1)(i)  High risk, high volume, or problem-prone area  (i) Focus on high risk, high volume, or problem-prone areas;	sponsible tive action is cur.  11/11/2020  strator on the uding the nt nt plans e or ne Director pleted the ve your pl cy's 3rd Director the tagainst ce	and Administrator are responfor monitoring the corrective at to ensure the deficiency is corrected and will not recur.  G 648  The Director and Administrate have been re-educated on the Agency's Performance Improvement Policy, including requirement to implement performance improvement plator high-risk, high-volume or problem-prone areas. The Director of Clinical Services completed HHQI QAPI course, "Pave yo Path," for additional QAPI education and training.  Beginning with the Agency's quarter QAPI report, the Director of Clinical Services and Administrator will review the Agency's quarterly report again the Agency's Performance	G 0648	ed OASIS data for skilled care replied "Yes." When queried in included any measures and OBQM, the DOCS ing what those terms meant the acronyms were provided. QAPI program included any om OASIS reports, the DOCS administrator and the DOCS indicated having nothing in review.  The policy indicated having nothing in review.  The policy which required the erformance improvement focused on high-risk, oblem-prone areas for 1 of 1 to 2020 QAPI program.  The policy stated, " Special formance Improvement actions isk, high-volume, or so, and will consider incidence, erity of problems in those	agency had submitted patients, the DOCS if the QAPI program derived from OBQI indicated not know after the names of the When queried if the measures derived from the problem of the pr	

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 57 of 84

CENTERS FOR MEDICARE & MEDICAID SERVICES					OM	IB NO. 0938-039	
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  15K141	A. BU B. WI	JILDING NG	00	COMPL 09/18/	
		13/(141	B. WI			09/10/	72020
	PROVIDER OR SUPPLIER			555 E (	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10	)5	
TOGETH	IER HOMECARE			GREEN	NWOOD, IN 46143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION
TAG		ailed to evidence any		TAG	QAPI report is compliant with		DATE
		vement plans. Review of QAPI			Agency's policy, including the		
		aint log evidenced high risk			implementation of performance		
	area of patients with	h falls, high volume area of			improvement plans for high-ris	sk,	
		nisconduct and missed visit			high-volume or problem-prone	<b>.</b>	
		oblem prone area of missed care			areas. This validation will con-		
	visits.				quarterly to ensure compliance		
	0 0 10 2020 4 12				maintained. Conformance of t	he	
		2 noon, the administrator and cal services (DOCS) verified			Agency's QAPI efforts to the	alia.	
		and both indicated the agency			Performance Improvement Powerland Will be reported to the Govern	-	
	had not identified o				Body during quarterly QAPI	irig	
		vement plans based on			reviews to ensure the deficien	ICV	
high-risk, high-volume, or problem-prone areas.				does not recur.	· · ·		
		litional pertinent information,			The Director of Clinical Service	es	
	explanation, or doci	umentation, the administrator			and Administrator are respons	sible	
	and DOCS indicate	d having nothing further to			for monitoring the corrective		
	present for review.				actions to ensure the deficien	cy is	
					corrected and will not recur.		
G 0654	484.65(c)(2)						
	Track adverse pat	tient events					
Bldg. 00		ovement activities must					
J		ent events, analyze their					
	1	ement preventive actions.					
			G 0	654	G 654		11/11/2020
	Based on record rev	view and interview, the agency			The Administrator and Directo	or of	
		its policy which required the			Clinical Services have been		
		and performance improvement			re-educated on Agency's		
		llected and analyzed data for			Performance Improvement Po	-	
	•	ts for 1 (2020) of 1 year of			including the tracking and ana	ılysis	
	QAPI reviewed.				of adverse patient events to	<del></del>	
	The findings in al 1	ad:			implement preventive actions.		
	The findings includ	cu.			Director of Clinical Services has completed the HHQI	as	
	Review of a policy,	"Performance			University QAPI training, "Pav	/e	
		ated, evidenced the policy			your Path," for additional QAP		
	stated, " The ag				education and guidance.	•	
		am consists of, but is not			Beginning with the Agency's 3	3rd	

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

limited to, the following: ... Adverse events ...

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

quarter QAPI report, the Director

Page 58 of 84

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		(X2) MULTIPLE ( A. BUILDING B. WING	construction 00	(X3) DATE SURVEY  COMPLETED  09/18/2020	
	PROVIDER OR SUPPLIER		555 E	T ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 1 ENWOOD, IN 46143	05
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
G 0658 Bldg. 00	Incident reports measured, and analymonitor its perform Review of QAPI da 9-18-2020, failed to measurement, or an or incident reports.  On 9-18-2020, at 12 the director of clinic the 2020 QAPI bindevidence the QAPI measured, and analy The administrator a indicated they consi an adverse event repterms. The administrator agency had not follot there were reported When asked for add explanation, or doct and DOCS indicated present for review.  484.65(d)(1)(2) Performance improstandard: Perform projects. Beginning July 13 performance improvement project.	ta from 2020 on 9-17 and evidence collection of data, alysis of adverse event reports  2 noon, the administrator and cal services (DOCS) reviewed der and were unable to provide program had collected, yzed adverse event reports.  Ind DOCS, when queried, dered an incident report and port to be interchangeable trator and DOCS verified the lowed their own policy and adverse events in 2020.  Ititional pertinent information, amentation, the administrator del having nothing further to	TAG	of Clinical Services and Administrator will review the Agency's quarterly report aga the Agency's Performance Improvement Policy to ensure QAPI report is compliant with Agency's policy, including the analysis of adverse events an implementation of preventive measures. This validation will continue quarterly to ensure compliance is maintained. Conformance of the Agency's QAPI efforts to the Performan Improvement Policy will be reported to the Governing Bo during quarterly QAPI review ensure the deficiency does no recur. The Director of Clinical Servic and Administrator are respon for monitoring the corrective actions to ensure the deficier corrected and will not recur.	e the  e hod  I  s hoce  dy s to ot ces sible
	performance of the operations.  (2) The HHA must	e HHA's services and document the quality ects undertaken, the			

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 59 of 84

12/01/2020 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/18/2020 15K141 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 555 E COUNTY LINE ROAD SUITE 105 GREENWOOD, IN 46143 TOGETHER HOMECARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE reasons for conducting these projects, and the measurable progress achieved on these projects. G 0658 G 658 11/11/2020 Based on record review and interview, the agency The Administrator and Director of failed to ensure its quality assessment Clinical Services have been performance improvement (QAPI) program re-educated on the implementation addressed the past performance of the home of an annual Performance health agency's services and operation, by having Improvement Project as part of the failed to implement performance improvement Agency's QAPI program. projects designed to show measurable progress The Director of Clinical Services for 1 (2020) of 1 year reviewed. and Administrator will propose and construct an annual performance The findings included: improvement project for 2020 prior to the end of the calendar year. Review of a policy, "Performance Improvement," The performance improvement undated, evidenced the policy stated, " ... Special project will address the Agency's Instructions ... Performance Improvement actions past performance and will be will focus on high-risk, high-volume, or designed to measure the progress problem-prone areas, and will consider incidence, of the project's implementation. prevalence, and severity of problems in those This plan will be included in the areas ... " Agency's 4th quarter QAPI report. The Administrator and Director of On 9-17 and 9-18-2020, the QAPI program for 2020 Clinical Services will continue to was reviewed and failed to evidence any ensure that at least one annual performance improvement plans. Review of QAPI Performance Improvement Project data and the complaint log evidenced high risk is implemented for each calendar area of patients with falls, high volume area of year. The presence and progress patient with HHA misconduct and missed visit of any Performance Improvement complaints, and problem prone area of missed care Project(s) will be documented visits. within the Agency's quarterly QAPI reports and reported to the On 9-18-2020, at 12 noon, the administrator and Governing Body to ensure the director of clinical services (DOCS) verified continued compliance. the above findings and both indicated the agency The Director of Clinical Services had not identified or implemented any and Administrator are responsible performance improvement plans since 2016, based for monitoring the corrective on high-risk, high-volume, or problem-prone actions to ensure the deficiency is areas. When further queried, the administrator

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

and the DOCS could not identify any PIPS

Event ID:

ZP5711

Facility ID: 013867

corrected and will not recur.

If continuation sheet

Page 60 of 84

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		15K141	B. W	ING		09/18/2020	
	PROVIDER OR SUPPLIER		-	555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 IWOOD, IN 46143	)5	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	deficiencies from the or from agency survadditional pertinent documentation, the	gency to address identified their own data, OASIS reports, veys. When asked for information, explanation, or administrator and DOCS thing further to present for					
G 0708	484.75(b)(2)						
Bldg. 00	Development and evaluation of plan of care Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s);  Based on record review and interview the agency failed to ensure the evaluation of the plans of care for 2 (Patients #1 and 6) of 6 clinical records reviewed.  The findings included:  1. Review of a policy, "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		G 0	708	G 708  All RN Clinical Supervisors had been re-educated on the evaluation of the aide care plat including the appropriateness the care plan tasks in relation each patient's wants and need All current aide care plans we immediately audited by the Director of Clinical Services to ensure the presence of a minit weekly bathing threshold when applicable.  The Director of Clinical Service RN designee will audit 100% onew Aide Care Plans for 30 datto ensure continued 100% compliance with establishing a minimum number of baths/showers per week to be provided to the patient by the home health aide for patients baths/showers on their care plants of the process of the process of the process of the process of the patient of the patient by the home health aide for patients baths/showers on their care plants of the process of the pro	of to ds. re mum n es or of ays	11/11/2020
		inical record for patient #1, care of 7-5-19, and contained			designee will include review o Aide Care Plans during the	†	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  09/18/2020
	PROVIDER OR SUPPLIEI	3	555 E	ADDRESS, CITY, STATE, ZIP CO COUNTY LINE ROAD SU NWOOD, IN 46143	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION JULD BE PROPRIATE  COMPLETION DATE
	a plan of care for the 9-2-2019, with order days per week. The Multiple Myelomanincluded "endurance hour duties enumer included: Bathir used during bathing Hygiene and Groor PRN; Assist with Noressing, PRN; Ha The registered nurse appropriateness of relation to ensuring schedule minimum needed.]  3. Review of the clevidenced a start of contained a plan of of 5-12 to 7-10-202 services. The plan of Dravet Syndrom developmental dela and concentration conon-obstructive alvegeneralized epileps obesity; and gastros Review of the plan nurse had evaluated was individualized management plan.  4. On 9-18-2020, at the director of clinithe above findings, pertinent informatic documentation, the	re certification period of 7-5 to ers for home health aide care 5-7 e primary diagnosis was  Functional limitations listed be." HHA prior authorization ated on the plan of care now shower chair/bench to be against with Shower: PRN; ming: Assist with Shampoo lail Care PRN; Peri Care PRN. e failed to evaluate the the medical plan of care in a shower/bath was ordered on a frequency rather than PRN [as tinical record for patient #4, and care for the certification period 20, with orders for skilled nursing of care evidenced diagnoses e and comorbidities of and comorbidities of the complex properties of the certification period electricity sleep related to evidence the diagnoses to the certification of the complex properties and epileptic syndromes; stomy [feeding tube] status. Of care failed to evidence the diagnose the plan of care to ensure it to contain a seizure care and the 4 P.M., the administrator and cal services (DOCS) verified and when asked for additional		Agency's quarterly QAF clinical record audit to e compliance is maintaine. The Administrator and I Clinical Services are resfor monitoring the correct to ensure the deficiency recur.	PI 10% insure ed. Director of sponsible ctive action

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 62 of 84

i ´		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					
		15K141	B. WI	nG		09/18/	2020
	PROVIDER OR SUPPLIER	8		STREET ADDRESS, CITY, STATE, ZIP COD  555 E COUNTY LINE ROAD SUITE 105  GREENWOOD, IN 46143			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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
	410 IAC 17-14-1 (a	)(1)(C)					
G 0714	484.75(b)(5)						
	Patient and careg						
Bldg. 00	Patient and careg	iver education;					
	Based on record reversal failed to ensure the documented education care for 1 (Patient # skilled services, in a skilled services in contained a plan of of 5-12 to 7-10-202 services. The plan of Dravet Syndromodevelopmental dela and concentration developmental dela and concentration dela dela dela dela dela dela dela dela	view and interview, the agency nurses provided and ion as ordered on the plan of 44) of 2 patients who received a sample of 6 patients.  ed:  cal record for patient #4, care date of 5-12-2020, and care for the certification period 0, with orders for skilled nursing of care evidenced diagnoses e and comorbidities of y; cognitive delay; attention leficit; sleep related eolar hypoventilation; other y and epileptic syndromes; stomy [feeding tube] status.  nurse visit notes from the failed to evidence education	G 0	714	All nurses have been re-education the provision and documentation of education in accordance with the Plan of Cincluding the description of the education provided.  The Director of Clinical Servicidesignee will review 100% of nursing notes for 2 weeks to ensure 100% compliance. Aft weeks of 100% compliance, the Director of Clinical Services were view the most recent 2 week nursing notes during the Agent quarterly QAPI 10% clinical reaudit to ensure compliance withis requirement is maintained. The Director of Clinical Service responsible for monitoring this corrective action to ensure the deficiency is corrected and will	are, es or er 2 ne ill ks of ccy's cord th l. es is	11/11/2020
	plan of care in relat seizure precautions. Review of the clinic evidenced a start of contained a plan of of 7-11 to 9-08-202 services. The plan of Dravet Syndromo	ocumented as ordered on the ion to non-verbal pain cues, and fall precautions.  cal record for patient #4, care date of 5-12-2020, and care for the certification period 0, with orders for skilled nursing of care evidenced diagnoses e and comorbidities of y; cognitive delay; attention efficit: sleep related			recur. Completed 11/11/2020 ongoing.	and	

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 63 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION NG <u>00</u>	СОМІ	e survey pleted 8/2020	
	PROVIDER OR SUPPLIER	2	55	REET ADDRESS, CITY, STATE, ZI 5 E COUNTY LINE ROAD REENWOOD, IN 46143		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF	CROSS-REFERENCED TO I	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 0716 Bldg. 00	generalized epileps obesity; and gastros Review of the daily certification period was provided and d plan of care in relat seizure precautions  On 9-18-2020, at 4 director of clinical above findings, and pertinent informatic documentation, the provided indicated present for review.  484.75(b)(6)  Preparing clinical	administrator and DOCS having nothing further to  notes notes;  view and interview, the employees B and C) failed to nical record accurate and s for the care furnished for 1 tients who received skilled a sample of 6 patients whose we reviewed.	G 0716	G 716 All nurses have bee on the accuracy of of documentation in active Plan of Care or consistency of documents throughout a nursing nurses have been recontact the office im there is a discrepanthe Plan of Care and of the patient's physicassessment so that can be contacted, a be written as necessed Administrator will be for ensuring that any employee receives a distributed as part of plan of correction, p	clinical coordance with ders, as well as mentation g note. All e-educated to imediately if cy between d a component sical the Physician and orders can sary. The e responsible y inactive all in-services of the Agency's	11/11/2020

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 64 of 84

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15K141		 JILDING	00	COMPL 09/18/	ETED	
NAME OF PROVIDER OR SUPPLIER  TOGETHER HOMECARE			555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 IWOOD, IN 46143	5	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Review of the clinic evidenced a start of contained a plan of of 7-11 to 9-08-202 services "Medicaid 1 visit/day X [sic fo Medicaid PA [prior (Skilled Nursing) T to schedule these he hours/day X 4-6 day Hours (Skilled Nursing) To schedule on an asnorare evidenced diag and comorbidities of cognitive delay; attending to the properties of the properties o	cal record of patient #4 Care date of 5-12-2020, and care for the certification period 0, with orders for skilled nursing State Frequency and Duration or 4-6 days/week for 9 weeks; authorization] Program Hours the patient's mother has chosen ours as follows 6.5 - 10.5 ys/week Medicaid Respite sing) The patient is authorized that the patient's mother will eeded basis." The plan of gnoses of Dravet Syndrome of developmental delay; ention and concentration of non-obstructive alveolar mer generalized epilepsy and se; obesity; and gastrostomy se. Feedings were ordered as: d 240 mL per gastrostomy tube, sind 240 mL pediasure +220 mL of mL Pediasure +220 mL of mL Pediasure +220 mL water fi [patient #4] eats greater than -240 mL Pediasure + 220 mL ovater if patient #4 eats greater 2100 240 mL Pediasure ethensive assessment dated ed patient #4 had an 18 french, balloon was not defined]		switched to "active" status and placed in the schedule. The Director of Clinical Services or designee immediately audited skilled nursing patients with gastrostomy status to ensure a discrepancies between the Placare and nursing note were addressed with the Physician a clarified with an order as necessary. All clinical records now 100% compliant. The Director of Clinical Service designee will review 100% of nursing notes for patients with gastrostomy for 2 weeks to encompliance with accurate and consistent documentation is maintained. After 2 weeks of 100% compliance, the Director Clinical Services or RN design will review nursing notes as pathe Agency's quarterly QAPI 1 clinical record audit to ensure compliance is maintained. The Director of Clinical Service responsible for monitoring this corrective action to ensure the deficiency is corrected and will recur.	RN all any in of and are es or a sure r of ee int of 0%	

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 65 of 84

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	of Correction identification number 15K141	A. BUILDING B. WING	00	COMPLETED 09/18/2020
	PROVIDER OR SUPPLIER	555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 IWOOD, IN 46143	5
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	mL balloon. On the drawing of the integumentary system, the nurse documented the gastrostomy tube was 14 french with a 5.5 mL balloon. The visit note documented education had been provided related to fall safety. The visit note failed to document the content of the education provided and which fall safety measured were reviewed.  Review of a skilled nursing visit notes evidenced a visit note dated 8-13-2020, by employee C, a registered nurse, and evidenced documentation			
	patient #4's gastrostomy stoma was WNL [within normal limits] and elsewhere in the note documented the stoma site was red. This information was contradictory. The visit note documented education had been provided related to fall safety. The visit note failed to document the content of the education provided and which fall safety measured were reviewed.			
	Review of a skilled nursing visit notes evidenced a visit note dated 8-17-2020, by employee B, a registered nurse, evidenced documentation patient #4 had a size 14 french gastrostomy tube with a 5.5 mL balloon. The visit note had documentation inconsistent with other nursing visit note entries, with no explanation if the tube had been changed, or reason for the 14 french feeding tube. The visit note documented education had been provided related to fall safety. The visit note failed to document the content of the education provided and which fall safety measured were reviewed.			
	Review of a skilled nursing visit notes evidenced a visit note dated 8-18-2020, by employee B, a registered nurse, failed to evidenced documentation of patient #4's gastrostomy tube size and balloon size. The visit note failed to			

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 66 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED	
		15K141	B. W	B. WING		09/18/2020	
NAME OF PROVIDER OR SUPPLIER  TOGETHER HOMECARE			555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 WOOD, IN 46143	5		
(V4) ID	CLIMMADY	CTATEMENT OF DEFICIENCIE	1	ID	·	1	(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROP			DATE
		nent of the gastrostomy					
	feeding tube stoma						
	_	ion had been provided related					
	to fall safety. The v	visit note failed to document					
	the content of the ed	ducation provided and which					
	fall safety measured	l were reviewed.					
		nursing visit notes evidenced					
		19-2020, by employee B, a					
	_	led to evidence date of last					
		evidenced documentation e 14 french gastrostomy tube					
	-	on. This documentation is					
		e documentation from					
		risit note documented education					
		related to fall safety. The visit					
	_	nent the content of the					
		and which fall safety					
	measured were revi						
		P.M., the administrator and the					
		services (DOCS) verified the					
		stated the registered nurse complete, accurate, and free					
		cumentation. When queried					
	•	information, explanation, or					
	•	administrator and the DOCS					
	·	thing further to present to be					
	reviewed.						
	410 IAC 17-14-1 (a	)(1)(E)					
0.0000							
G 0802	484.80(g)(3)						
Bldg 00	Duties of a HH aid						
Bldg. 00		me health aide include:					
		f hands-on personal care; ce of simple procedures as					
	, ,	erapy or nursing services;					
		ambulation or exercises;					
	and	ambalation of cholosos,					

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 67 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		A. B	A. BUILDING <u>00</u>			SURVEY LETED /2020	
	PROVIDER OR SUPPLIE	3		555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 NWOOD, IN 46143	)5	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NOY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY.	λΤΕ.	(X5) COMPLETION
	(EACH DEFICIENT REGULATORY OF CIV) Assistance in ordinarily self-adrialed to ensure a hassigned care tasks hands on care, the procedures as an exassistance in ambut assistance with administration or are for 1 (Patient a health aide only self having assigned however ordinarily self having assigned at task with direct patient care, director of clinical	administering medications ninistered.  view and interview, the agency ome health aide (HHA) included only the provision of performance of simple stension of nursing services, lation or exercises, and ninistering medications which f-administered, to include me health aide duties of pet 44) of 4 patients with home rvices, out of a sample of 6	G 0		(EACH CORRECTIVE ACTION SHOULD BE	ave ment are, pet ide ed and es for asure er 30 e r RN f the	
	Programs, which in	dicated home health agencies  HA on prior authorization					

	WIEDICAKE & MEDIC				OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		15K141	B. WING		09/18/2020	
NAME OF PROVIDER OR SUPPLIER  TOGETHER HOMECARE		555 E (	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 NWOOD, IN 46143	05		
	Т			I		
(X4) ID		STATEMENT OF DEFICIENCIE	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		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
	may choose to have provide." The request (3) were shared with director of clinical states the provision of har performance of simulation or exercing ambulation or exercing medication ordinarial administrator and the provide states of the request.	sk the home health agency the home health aide airements of 42 CFR 484. 80 (g) the the administrator and the services (DOCS) which were: ads on personal care; the ple procedures as an extension ag services; assistance in cises; and assistance with ly self-administered. Both the are DOCS indicated believing C"pet care" for PA services for ct.				
G 0818	484.80(h)(4)(i-vi)					
Bldg. 00	that aides furnish manner, including following elements (i) Following the p completion of task health aide by the appropriate skilled (ii) Maintaining an process with the pany), caregivers, a (iii) Demonstrating tasks; (iv) Complying wit control policies and	supervision must ensure care in a safe and effective , but not limited to, the s: atient's plan of care for as assigned to a home registered nurse or other d professional; open communication patient, representative (if and family; g competency with assigned th infection prevention and ad procedures; nges in the patient's				
	Based on record rev failed to ensure sup health aide were reg with the home healt	view and interview, the agency ervisor visits of the home gularly reviewed for compliance th aide care plan as required by (Patient #1) of 4 patients with	G 0818	G 818 All HHAs and CNAs have bee re-educated regarding properl documenting the reason for no completing a task during a vis All RN Clinical Supervisors ha	y ot it.	

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 69 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		r í	UILDING	ONSTRUCTION 00	(X3) DATE COMPL 09/18/	LETED	
	PROVIDER OR SUPPLIE	R	<u> </u>	555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 IWOOD, IN 46143	)5	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.IE	DATE
	home health aide o	nly services, of a total of 6			been re-educated on the care		
		ical records were reviewed.			planning process for home he	alth	
	The findings included:				aide tasks, as well as the need review the appropriateness of aide care plan based on patie	d to the	
	Davious of a policy	"Supervisory Visit of			I		
		, "Supervisory Visit of reviewed/revised 8-21-2019,			condition and aide documenta at supervisory visits.	IUOH	
		by stated, "All staff providing			The Director of Clinical Servic	oc or	
		will be supervised as outlined			RN designee will audit 100%		
		e regulations and accepted			supervisory visit forms and a	וכ	
	1 -				sample of the related home he	oolth	
	standards of practice Purpose To ensure staff are demonstrating competence in the areas of				aide notes for 30 days to ensu		
	communication, identifying and responding to				the Agency maintains complia		
	patient needs, and performing				with review of the aide care pl		
		ues properly Documentation			supervisory visits. Once	an at	
		s will be reviewed regularly			compliance has been maintain	ned	
		's Notes QA process, clinical			for 30 days, the Director of Cli		
	record audits, and l	· •			Services or RN designee will	riiodi	
					include supervisory visits as a	ı	
	Review of the supe	ervisory visit notes for patient			component of the Agency's 10		
	_	evidenced the following:			quarterly clinical record audit.		
		S			The Director of Clinical Servic	es is	
	"Employee Present	: Home Health Aide [no name			responsible for monitoring this	3	
	documented]	-			corrective action to ensure the		
	Employee followin	g orders/Plan of Care: Yes			deficiency is corrected and wil	ll not	
					recur.		
	Aide Care Plan Re	viewed During Visit? Yes "			Completed 10/21/20 and ongo	oing.	
	Review of the hom	e health aide (HHA) visit notes					
		dated 7-5-2019, for the					
	_	of 7-5 to 9-2-2019, evidenced					
	_	wer/ bath was ordered once a					
		needed); there was no bath/					
	,	d from 7-14 to 8-2-19, which					
		s with no documentation					
	_	been met. The supervising					
		of clinical services (DOCS),					
		the HHA had not followed the					
		relation to provision/ assistance					
	_	giene need of shower/bath for					

f ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED	
		15K141	B. WI	B. WING		09/18/	2020	
	PROVIDER OR SUPPLIER			555 E C	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 IWOOD, IN 46143	5		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	Ι	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY 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	
G 0940 Bldg. 00	3 weeks.  On 9-4-2020, at 2:1 verified with the adi When asked why pathe DOCS stated it hygiene and ambula asked for additional explanation, or document and DOCS indicates present for review.  484.105 Organization and a Condition of particular administration of SThe HHA must orgadminister its resomaintain the higher capacity, including achieve the goals the patient's plan of medical, nursing, a The HHA must assupervisory function another agency or services not furnistical another agency or services not furnistical and controlled. The writing, its organization of Stailed to maintain organization of Stailed to be responsitely operations of the hot of ailure to provide addresses of member and services of member and controlled addresses of member and services of member and services are services and for a services and for a services and furnished to be responsitely addresses of member and services are services.	5 P.M., the above findings were ministrator and the DOCS. Intent #1 had HHA services, was for safety and to meet action/ transfer needs. When pertinent information, amentation, the administrator of thaving nothing further to administration of services aparize, manage, and surces to attain and set practicable functional providing optimal care to and outcomes identified in of care, for each patient's and rehabilitative needs. Sure that administrative and ons are not delegated to organization, and all hed directly are monitored to HAA must set forth, in ational structure, including and services furnished.	G 09		G 940 Per ISDH instruction, a response is not recommende for this tag due to the absence of any cited findings.		10/21/2020	

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet Page 71 of 84

PRINTED: 12/01/2020

	T OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COM	TE SURVEY IPLETED 18/2020
NAME OF PROVIDER OR SUPPLIER TOGETHER HOMECARE			EET ADDRESS, CITY, STATE, ZIP 5 E COUNTY LINE ROAD S			
			EENWOOD, IN 46143			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFI	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION
TAG	and documented in ensure all complain complete resolution allegations of abuse follow-up actions to assessment of an in interventions to proto ensure the agence performance impro adverse events and performance impro director of clinical patient with an injury were continually as director of clinical ensure patients' pla updated (See G 968). The cumulative efforcesulted in the homensure the provision safe environment for	ect of these systemic problems e health agency's inability to n of quality health care in a or the Condition of ganization and Administration	TAG			DATE
Bldg. 00	Responsible for a (ii) Be responsible	ll day-to-day operations e for all day-to-day				
	administrator failed day-to-day operation in relation to failure current addresses of body; failure to ens	wiew and interview, the I to be responsible for the ons of the home health agency to provide the names and f members of the governing ure all complaints were umented in the complaint log;	G 0948	G 948 Agency has created a with names and addre Governing Body mem provide upon request. All Together Homecal have been contacted there are no outstand	esses of hbers and will . re patients to ensure	11/24/2020

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

failure to ensure all complaints had a responsive

and complete resolution documented; failure to

ensure allegations of abuse/neglect had

Event ID:

ZP5711

Facility ID: 013867

unreported complaints, including

those related to verbal, physical,

sexual or mental abuse, neglect,

If continuation sheet

Page 72 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLET	TED
		15K141	B. W	ING		09/18/20	020
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			COUNTY LINE ROAD SUITE 10	)5	
TOGETH	IER HOMECARE				NWOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOUISERS NV		(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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IIE .	DATE
	documented follow	-up actions to include a			injuries of unknown origin or		
	complete nursing as	ssessment of an injury of			misappropriation of property. I	No	
	unknown origin and	d interventions to protect all			additional concerns regarding	new	
	agency patients; fai	led to ensure the agency			or previously reported or		
	quality assurance as	nd performance improvement			unreported abuse		
	(QAPI) program tracked adverse events and				(verbal/physical/emotional/sex	kual),	
	complaints, and conducted performance				neglect, misappropriation of		
	improvement plans,	, for 1 of 1 agency			property or injuries of unknow	n	
	administrator.				origin have been identified.		
					Additionally, the Administrator	and	
	The findings included:				Director of Clinical Services		
					completed a 100% review of a	all	
	_	16-2020 at 12 noon, for the			patients who filed complaints	in	
	names and current a	addresses of the members of			2020 regarding abuse or negl	ect in	
	the governing body	, the administrator failed to			2020. Those complainants ha	ve	
	provide the information	ation prior to survey exit.			been contacted by the		
					Administrator and/or Director	to	
		ailed to ensure all complaints			ensure they have no further		
		d documented in the complaint			concerns regarding the report	ed	
		re all complaints had a			complaint, or any ongoing issu	ues	
	_	plete resolution documented			or concerns related to Patient		
	(See G 484.)				Rights. The Administrator has		
					verified that all allegations of		
		ailed to ensure allegations of			abuse or neglect have been		
	_	locumented follow-up actions			thoroughly investigated and		
	_	te nursing assessment of an			resolved, and no further action		
		origin and failure to implement			are required to ensure patient		
	_	tect all agency patients (See G			safety. To ensure that the		
	482.)				Agency's investigative proces		
					thorough and clear, the Agend	-	
		ailed to ensure plans of care			Patient Complaint Policy (C-3	81)	
		sit orders were rationally			was modified to include more		
		t's assessed needs (See G			detailed instructions for obtain	-	
	572.)				and reviewing evidence in the		
					investigative process, includin	g	
		ailed to ensure the agency			requesting, reviewing and		
		nd performance improvement			documenting the contents of a	-	
		entified areas for improvement			audio or video evidence relate		
		rom available data, failed to			the complaint. An Investigation	n	
	ensure the agency c	onducted performance	I		Guidance form was created to	,	

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15K141	B. W	ING		09/18/	/2020
		L		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R		1	COUNTY LINE ROAD SUITE 10	)5	
TOGETH	IER HOMECARE			GREEN	WOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		s, tracked adverse events, and			further facilitate a thorough		
	_	s as required by agency policy			investigative process and will	be	
	(See G 642, G 644	, G 648, G 654, and G 658.)			utilized for each complaint to		
	0 0 10 2020 4 4	20 D.M. 1 1 1 C			ensure a thorough and compl		
		:20 P.M., when asked for			investigation with proper follow	-	
	additional pertinent information, explanation, or documentation, the administrator indicated having				The complaint form has also be		
	nothing further to				updated to ensure that a com and responsive resolution is	piele	
	nothing further to p	bresent for feview.			documented and communicat	od to	
					the complainant following the	eu io	
	410 IAC 17-12-1 (	c)(1)			Agency's investigation. All into	arnal	
	410 1110 17-12-1 (	(1)			employees were educated on		
					new complaint policy (C-381)		
					complaint forms.	ana	
					The Administrator and Director	or of	
					Clinical Services are responsi		
					for documenting and investiga		
					all complaints in accordance	-	
					Agency policy and state and		
					federal regulations, and to en	sure	
					patients are free from all abus		
					injuries of unknown origin and	l	
					misappropriation of property a	at all	
					times.		
					Administrator and Director of		
					Clinical Services will audit 100	0% of	
					complaints for 60 days to ens	ure	
					the investigative process is		
					thoroughly documented and		
					complies with Agency's policy	′	
					(C-381). Once Agency has		
					maintained 100% compliance	for	
					60 days, Administrator and		
					Director of Clinical Services w		
					audit 20% of complaints quar	terly	
					to ensure compliance is		
					maintained.		
					All active purees have been		
					All active nurses have been		
			1		re-educated regarding the		I

If continuation sheet

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/01/2020 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC					OM	IB NO. 0938-039
	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPI	
		15K141	B. W			09/18	12020
NAME OF P	PROVIDER OR SUPPLIE				ADDRESS, CITY, STATE, ZIP COD		
TOCETU					COUNTY LINE ROAD SUITE 10	J5	
IOGETH	ER HOMECARE			GREEN	NWOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
					completion of a full patient		
					assessment for any change in		
					condition, including injuries of unknown origin or stemming f		
					alleged/suspected abuse or	10111	
					neglect. The re-education incl	uded	
					the requirement of all		
					comprehensive assessments	to	
					include a full description of an		
					wounds, including description	of	
					the wound and measurements	s, as	
					well as a skin assessment to	look	
					for any additional wounds. All		
					active nurses have acknowled	-	
					understanding of this re-educa	ation.	
					The Administrator will be		
					responsible for ensuring that a	-	
					inactive employee receives al		
					in-services distributed as part		
					the Agency's plan of correctio		
					prior to being switched to "act status and placed in the sche		
					status and placed in the sched	uule.	
					Administrator and Director of		
					Clinical Services will audit 100	0% of	
					complaints for 60 days to ens		
					they contain evidence of a		
					completed head-to-toe		
					assessment in situations of		
					alleged abuse or injuries of		
					unknown origin. Once Agency		
					maintained 100% compliance	for	
					60 days, Administrator and		
					Director of Clinical Services w		
					audit 20% of complaints quart	terly,	
					as part of the Agency's QAPI		
					program, to ensure compliance	e is	
					maintained.		1

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

All internal employees have been

Page 75 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SU COMPLE 09/18/2	TED		
	ROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 555 E COUNTY LINE ROAD SUITE 105 GREENWOOD, IN 46143					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE		
				re-educated that each prindividualized frequency duration is developed in collaboration with the pand/or family and will be by the managing Physic frequency and duration based on the patient coinformal support status, order, and patient/famil Any such changes must documented according clinical record. Missed and/or supplemental or continue to be utilized trany deviations from the frequency and duration will make every effort to any missed visits within week.  The Director of Clinical RN designee will audit outgoing plans of care to ensure that each pat nursing or home health frequency and duration compliant with the requency and duration compliant with the requency and compliant with the requency of Clinical Services will continue to evaluation of the frequency and part of the Agency's quelinical record audit to econtinued compliance. The Administrator and I Clinical Services have to	y and n atient e approved cian. The may evolve ondition or physician y request. to be ly in the visit notes ders will o report ordered Agency o make up of the work  Services or 100% of for 30 days ient's aide remains irement. e has been to the vices or RN to include ency and e to the duration as arterly 10% ensure			

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 76 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  15K141	A. BUILDING B. WING	00	COMPLETED 09/18/2020
	PROVIDER OR SUPPLIEF	2	555 E (	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 NWOOD, IN 46143	25
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
				re-educated on the Agency's QAPI program, including reviet the Agency's Performance Improvement Policy (B-260). The Director of Clinical Services has also enrolled in HHQI University additional QAPI education and guidance.  Beginning with the Agency's 3 quarter QAPI report, the Director of Clinical Services and Administrator will review the Agency's quarterly report again the Agency's Performance Improvement Policy to ensure QAPI report is compliant with Agency's policy, including the analysis of adverse events and presence of performance improvement plans for high-rishigh-volume or problem-prone areas. This validation will continguarterly to ensure compliance maintained. Conformance of the Agency's QAPI efforts to the Performance Improvement Powill be reported to the Governi Body during the quarterly QAF review.  The Director of Clinical Service and Administrator will propose construct an annual performar improvement project for 2020 to the end of the calendar year The performance improvement project for 2020 to the end of the calendar year The performance and will be designed to measure the progof the project's implementation This project will be included in	The as ity for a distribution of the ast

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 77 of 84

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED	
		15K141	B. W	NG		09/18/	/2020	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIEF	8			COUNTY LINE ROAD SUITE 10	)5		
TOGETH	IER HOMECARE			GREENWOOD, IN 46143				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
					Agency's 4th quarter QAPI rep			
					The Administrator and Directo			
					Clinical Services will ensure th			
					at least one annual Performar	ice		
					Improvement Project is			
					implemented for each calenda	ır		
					year. The Administrator and Directo	r oro		
					responsible for monitoring the			
					corrective actions to ensure th			
					deficiency is corrected and wil			
					recur.	11100		
					Todan			
G 0966	484.105(c)(4)							
	Assure patient ne	eds are continually						
Bldg. 00	assessed							
	Assuring that pation	ent needs are continually						
	assessed, and							
			G 0	966	G 966		11/24/2020	
		view and interview, the director			All active nurses, including the			
		failed to ensure 1 (Patient #4)			Director of Clinical Services, h			
	_	injury of unknown origin			been re-educated regarding th	ıe		
		ally assessed, out of a sample			completion of a full patient			
	of 6 patients.				assessment for any change in			
	The findings includ	lad.			condition, including injuries of			
	The initialities includ	icu.			unknown origin or stemming fi alleged/suspected abuse or	OIII		
	Review of the clinic	cal record of patient #4			neglect. The re-education incl	uded		
		ned entry, dated 8-24-2020, into			the requirement of all	aucu		
		Report made by employee D,			comprehensive assessments	to		
		se manager, which evidenced			include full documentation of a			
	_	a home visit at patient #4's			wounds, including description	-		
		apervise, re-educate and train			the wound and measurements			
		stered nurse (RN,) and was			well as a skin assessment for			
		right upper thigh bruise. The			additional wounds. All active	-		
	_	supervisory nurse arrived			nurses have acknowledged			
	around 10 A.M. and	d patient #4's parent alleged			understanding of this re-educa	ation.		
	the "full-time nurse	may have hit the patient with			An assessment of Patient #4			
	her [patient #4's] ga	nit belt." The home had			completed by the Director of			
	cameras located eve	erywhere except the			Clinical Services in the preser	ice	1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		A. BUILI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  09/18/2020		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 555 E COUNTY LINE ROAD SUITE 105 GREENWOOD, IN 46143				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	believing the incide the bathroom, becaut the bathroom, and the bathroom, and the show patient #4 k Report entry by RN "called administration." The RN parent send the vide administration and the begin." The parent of full-time nurse is not during this investigate services failed to encomprehensive asseconducted to determ unknown origin were buring a query to the (DOCS), on 9-11-20 DOCS indicated has described above. The #4's was not provide assessment for furth on 8-24-2020. Whe information, explan administrator and Defurther to present for	further investigation will was informed "the patient's of allowed inside of the home ation." The director of clinical sure a complete head to toe assment for patient #4 was nine if any other injuries of the present.  The director of clinical services of the present and #2, the DOCS indicated patient the director of unknown origin the present asked for additional pertinent ation, or documentation, the of the patient's the patient'			of the patient's mother has revealed no evidence of injurier related to abuse or injuries of unknown origin, and the patient mother has affirmed that she is no additional concerns, including any concerns about abuse, sing the survey.  The Administrator and Director Clinical Services will audit 100 complaints for 60 days to ensure they contain evidence of a completed head-to-toe assessment in situations of alleged abuse or injuries of unknown origin. Once Agency maintained 100% complaints quart as part of the Agency's QAPI Program, to ensure compliance maintained.  The Director of Clinical Services was part of the Agency's QAPI Program, to ensure compliance maintained.	nt's nas ing nce r of 1% of ure thas for ill erly, ee is	
G 0968 Bldg. 00	Assuring the deve and updates of the Based on record rev of clinical services ( patients' plans of ca	ation of plan of care lopment, implementation, e individualized plan of care. riew and interview, the director (DOCS) failed to ensure re were evaluated and nts #1, 4, and 6) of 6 patients rds were reviewed.	G 096	8	G 968 All internal employees have be re-educated that each patient' individualized frequency and duration is developed in collaboration with the patient		11/11/2020

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  09/18/2020			
NAME OF P	ROVIDER OR SUPPLIEF		-		ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 1:	05		
TOGETH	ER HOMECARE			GREENWOOD, IN 46143				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION	
TAG	The findings includ	R LSC IDENTIFYING INFORMATION		TAG	and/or family and will be appr	oved.	DATE	
	The initings metad	cu.			by the managing Physician.			
	1. Review of a poli	cy, "Plan of Care," last			frequency and duration may			
	_	21-2029, evidenced "Home			based on the patient condition			
	care services are furnished under the supervision				informal support status, Phys			
		patient's physician. The plan			order, and patient/family requ	ıest.		
		a comprehensive assessment			Any such changes must be			
		ovided by the patient/family			documented accordingly in th	ie		
		mbers. Planning for care is a			clinical record. Missed visit no			
		at addresses the care,			and/or supplemental orders v			
		ces to be provided. The plan			continue to be utilized to repo			
	-	reviewed to ensure that			any deviations from the order			
	patient needs are met, and will be updated as				frequency and duration. Ager	•		
	-	ast every sixty (60) days The			will make every effort to make	-		
		e completed in full to include:			any missed visits within the w	ork/		
		uration of visits to me made			week.			
		l treatments Patient-specific lucation; measurable			The Director of Clinical Service			
					RN designee will audit 100%			
	outcomes and goals	• • • • • • • • • • • • • • • • • • • •			outgoing plans of care for 30 to ensure that each patient's	uays		
	2 Review of the cl	inical record for patient #1,			frequency and duration is			
		care of 7-5-19, and contained			compliant with the requirement	nt		
		e certification period of 7-5 to			Once 100% compliance has I			
	_	ers for home health aide (HHA)			maintained for 30 days, the	00011		
		equency and Duration: 1			Director of Clinical Services of	or RN		
		s/week for 9 weeks Medicaid			designee will continue to revi			
		rization] Program Hours: The			the frequency and duration as			
		o schedule PA hours as			of the Agency's QAPI quarter	•		
	follows: 1-5 hours/o	day X 3-5 days/week, 2-6 hours			10% clinical record audit to e	nsure		
	a day X 1-2 days/w	eek, 0.5- 4 hours/day X 1-3			continued compliance.			
	-	eaid Waiver Program Hours:			The Administrator and Director	or of		
	-	sen to schedule Waiver hours			Clinical Services are respons	ible		
		rs/day X 3-5 days/week, 2-6			for monitoring these correctiv			
	<u>-</u>	ys/week, 4-8 hours/day X 1-3			actions to ensure the deficien	icy is		
	days/week."				corrected and will not recur.			
	Review of HHA vis	sit notes with the director of						
	clinical services (D	OCS) 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 When							

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMPL	
		15K141	B. WINC	·		09/18/	2020
NAME OF F				STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C	;	555 E C	OUNTY LINE ROAD SUITE 10	5	
TOGETH	IER HOMECARE			GREEN'	WOOD, IN 46143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
	•	HA 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						
	_	essment, the clinical director					
	_	Review of the plan of care for					
	_	riod of 9-3 to 11- 1-2019,					
	_	or home health aide (HHA)					
		equency and Duration: 1					
		s/week for 9 weeks Medicaid					
		rization] Program Hours: The					
		to schedule PA hours as					
	_	day X 3-5 days/week, 2-6 hours					
		eek, 0.5- 4 hours/day X 1-3					
		caid Waiver Program Hours:					
	-	sen to schedule Waiver hours					
	-	rs/day X 3-5 days/week, 2-6					
		ys/week, 4-8 hours/day X 1-3					
		OCS failed to ensure the plan					
	of care was evaluat	ed and updated to ensure					
	HHA visit hours wl	nich reflected patient #1's					
	needs 3 hours for	PA, and 4-5 hours for Waiver,					
	7 days per week.						
	3. On 9-8-2020, at	approximately 1:15 P.M., when					
	asked for additional	l pertinent information,					
	explanation, or doc	umentation, the administrator					
	and DOCS indicate	d having nothing further to					
	present for review.						
	4. Review of the cl	inical 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 6.5 to 10.5 hours 4-6 days per week. The						
	plan of care evidenced diagnoses of Dravet						
	Syndrome and com	orbidities of developmental					
	delay; cognitive del	ay; attention and					
	I		1				i

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 81 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  09/18/2020
	PROVIDER OR SUPPLIEI	₹	555 E	ADDRESS, CITY, STATE, ZIP COUNTY LINE ROAD SUNWOOD, IN 46143	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) IOULD BE PPROPRIATE COMPLETION DATE
	generalized epileps	it; sleep related eolar hypoventilation; other y and epileptic syndromes; stomy [feeding tube] status.			
	certification period were consistently 8 care ordered on the hour range from 6.5 wide of a variation individualized to m DOCS failed to ens	ed nursing visit notes for the evidenced the nurse visits to 10 hours to provide the plan of care. The nurse visit 5 to 10.5 hours per visit was too for care orders and was not leet the patient's needs. The sure the plan of care was the hours of care required to leeds.			
	certification period orders for skilled m hours 4-6 days per ensure the plan of c	of care for patient #4, for the of 7-11 to 9-08-2020, with ursing services 6.5 to 10.5 week. The DOCS failed to eare was updated to reflect the red to meet patient #4's needs.			
	minor patient #4, w hours for the skilled to stay 8-10 hours t #4 required. When chosen to schedule on a range of 6.5 to stated wanting all that allowed, to include patient #4 stated the	1 P.M., the parent guardian of then queried about plan of care d nurse, stated the nurses had to provide all the care patient queried whether guardian had the skilled nursing care hours to 10.5 hours, the guardian he hours patient #4 was respite care. The guardian of the agency had never provided the to lack of staffing.			
	evidenced a start of contained a plan of of 8-17 to 10-15-20	finical record of patient #6 f care date of 8-17-2020, and f care for the certification period 020, with orders for HHA care ate Frequency and Duration: 1			

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 82 of 84

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141		JILDING ING	nstruction <u>00</u>	(X3) DATE COMPI 09/18/	ETED
	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP COD 555 E COUNTY LINE ROAD SUITE 105 GREENWOOD, IN 46143				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	I IATE	(X5) COMPLETION DATE
	visit/day X 6-7 day PA Program Hours wife have chosen to authorization] hour X 1-3 days/week, a days/week Medica (HHA) The patient schedule his Waive hours/day X 4-6 da diagnosis was docu Dystrophy, and evidependence and use HHA care duties or patient to keep DM Assistive Devices of Supervisor if any it attention assist w assist with ambulat lift must be used fo Hoyer lift or Stando used during bathing (Tuesday and Frida and PRN [as needed visit, assist with lau dishes every visit, to PRN, dust weekly a Shampoo weekly at Every visit, Peri can Handling/Bringing patient (No administ Reminders Every v Every visit, Follow with feeding, to ince PRN, Encourage FI Clinical Supervisor last BM date PRN, Assist to Commode identified as a high evidenced patient #	s/week X 9 weeks; Medicaid (HHA) The patient and his o schedule his PA [prior s as follows: 0.5 to 4 hours/day nd 5-9 hours/day X 4-6 id Waiver Program Hours it and his wife have chosen to r hours as follows: 0.5 - 4.5 ys/week." Patient #6 primary mented as Multiple denced wheelchair e of Hoyer lift for transfers. Idered for PA were Assist E [durable medical equipment]/ Itelan, and notify Clinical ems are in disrepair or require with wheelchair every visit, ion/transfers every visit, Hoyer r ALL patient transfers [use er] Shower chair/bench to be g, assist with shower y) Change bed linens weekly d,] Light Housekeeping every undry weekly assist with vacuum/sweep weekly and and PRN Assist with Dressing					

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

Event ID:

ZP5711

Facility ID: 013867

If continuation sheet

Page 83 of 84

PRINTED: 12/01/2020 FORM APPROVED OMB NO. 0938-039

ì	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	IA (X2) MULTIPLE CONSTRUCTION  A. BUILDING 00  B. WING		(X3) DATE SURVEY COMPLETED 09/18/2020			
NAME OF PROVIDER OR SUPPLIER TOGETHER HOMECARE			STREET ADDRESS, CITY, STATE, ZIP COD 555 E COUNTY LINE ROAD SUITE 105 GREENWOOD, IN 46143				
( )	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		TE	(X5) COMPLETION	
during working hour individualize the HH greater than 0.5 hour individualize the HH of visits which were #6's need for assistar daily living] when w  6. On 9-18-2020, at the DOCS verified the asked for additional explanation, or documents.	LSC IDENTIFYING INFORMATION  as. The plan of care failed to  IA visit hours to a minimum of  as for a visit, and failed to  IA care plan orders to ranges  rationally related to patient  ace with ADLs [activities of  rife was at full time job.  4 P.M., the administrator and  the above findings, and when  pertinent information,  mentation, the administrator  I having nothing further to		TAG	DEFICIENCY)		DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZP5711 Facility ID: 013867 If continuation sheet Page 84 of 84