STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>			COMPLETED	
		15K141	B. W	B. WING			01/11/2021	
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	\ <b>r</b>		
TOOFT					COUNTY LINE ROAD SUITE 10	15		
IOGEIR	IER HOMECARE			GREEN	NWOOD, IN 46143			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG				TAG	DEFICIENCY		DATE	
G 0000								
Bldg. 00								
		G 0	000	Together Homecare				
	This visit was for a	post condition revisit survey			("Together") submits the			
	of a Medicaid Hon	ne Health Agency. The original			following Plan of Correction	as		
	complaint survey,	IN 00307172; was substantiated			required by State and Federa	al		
	with related and un	nrelated findings, and resulted			law. Together's submission	of		
	in a full extended s	survey, with a date of exit of			this Plan of Correction shou	ld		
	9-18-2020.				not be taken as an agreemer	nt		
				with or admission of any of t	:he			
	Survey Dates: 1-5	, 1-6, 1-7, 1-8, and for return			findings contained therein.			
phone call from attending provider, 1-11-2021				Together hereby expressly				
					reserves the right to challeng	ge		
	Facility #: 013867				the factual findings, legal			
					conclusions, and allegations	;		
	CCN: 15K141				contained in the underlying			
					reports.			
		, exit date of 1-11-2021, 4			Compliance has been and w	ill		
		ficiencies were corrected; 16		be achieved no later than				
		ciencies were corrected; 7			last completion date identifie	∍d		
		ciencies were re-cited; and 5			in the Plan of Correction.			
	new standard level	deficiencies were cited.			Together desires this Plan of	of		
					Correction to be considered			
		ition-level deficiencies			our Creditable Allegation of			
	identified during th	ne 9-18-2020, survey, your home			Compliance.			
	, ,	subject to a partial or extended						
		section 1891(c)(2)(D) of the						
		t, on 9-9-2020 at 1:45 P.M.; for						
	_	ition level deficiencies: Patient						
	_	4.50; Care Planning,						
		Quality of Care, 42 CFR 484.60;						
		nt/Performance Improvement 42						
		Organization and Administration						
		R 484.105. Therefore, and						
	1 ^	1891(a)(3)(D)(iii) of the Act,						
		cluded from operating or being						
		health aide training and/or						
competency evaluation programs for two years								

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

TITLE

(X6) DATE

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.

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l i		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLE 01/11/2			
		15K141	B. WI			01/11/	12UZ I
NAME OF P	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10	)5	
TOGETH	ER HOMECARE				NWOOD, IN 46143		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX			COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION beginning 9-18-2020, and continuing through			TAG	BETEIENCT		DATE
	9-17-2022.	o, and continuing through					
	The deficiencies cited in this survey are reflected in findings cited pursuant to 410 IAC 17.  Quality Review Completed on 1/29/21						
G 0430	30 484.50(c)(2) Be free from abuse						
Bldg. 00	physical abuse, in	al, mental, sexual, and cluding injuries of unknown nd misappropriation of					
			G 0	430	All Agency nurses have been		02/05/2021
		view and interview, the agency			re-educated on the importance		
		registered nurse reported			reporting injuries of unknown	•	
	-	own origin to the Director of ly for 1 (patient #4) of 1 patient			to the Director of Clinical Serv		
	-	ntegumentary impairment, of a			immediately so that the Direct can complete an assessment		
	total sample of 5 pa				begin an investigation.  Additionally, all nurses have b		
	The findings includ	ed:			re-educated on the process for documenting any wound, inclu	or	
	Review of a plan of correction from a complaint survey that was conducted on 9/18/20, revealed that the agency indicated they would be in				measurement and full description of the area. All nurses have acknowledged understanding	tion	
		4/20, in regards to the			this in-service material. The		
		uries of unknown origin. The			Agency contacted all nurses to		
	•	evealed " All employees			ensure there are no outstanding	•	
		n patient rights, including the			unreported injuries of unknow		
	-	n all abuse, injuries of unknown			origin, and no further injuries of		
	origin To ensure investigative proces	ss is thorough and clear "			concerns have been identified this time.	al	
		of patient #4, Start of Care			The Director of Clinical Servic	es or	
	•	ved and contained a "Home and Plan of Care" for the			RN designee will complete a	ina	
		11/8/20-1/6/21, with orders for			focused audit of 100% of nurs notes for the RN mentioned in	_	

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

PRINTED: 02/17/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 01/11/2021				
	PROVIDER OR SUPPLIER	3	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 ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)  SURVEY PROOF (Employee E)	RIATE COMPLETION  DATE			
	from 8 AM- 4 PM, registered nurse, re "wounds present: so documentation of a bruise to the left kn thigh. The commentation of the patient) tends to pure asleep." The visit residentified scrape, by measured and failed the areas where the had been identified Director of Clinical notified of the injurting immediately.  A review of a skilled from 8 AM - 4 PM, registered nurse, re "wounds present: So documentation of a bruise to the left kn thigh. The commentation of a bruise to the left kn thigh. The visit note failed scrape, bruise, and and failed to evident where the integume identified and failed to origin immediately.  A review of a "Clied Areview of a "Clied Clied Commentation of a continuation of a cont	ent Logging Report,		survey report (Employee E) days to ensure compliance these requirements. Followidays of 100% compliance, the Director of Clinical Services designee will include an audituring notes during the Aground quarterly clinical record to ensure continued compliant. The Director of Clinical Servand Administrator are responsive monitoring these correct actions to ensure the deficiency corrected and will not recurred.	with ng 30 he or RN dit of ency's d audit ance. vices onsible			
	Employee B, the D mother and due to t	re" dated 12/4/20, evidenced OCS, spoke with the patient's the family being out of town, a for 12/7/2020, to assess the						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 01/11/2021			
	ROVIDER OR SUPPLIER ER HOMECARE		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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
G 0436 Bldg. 00	entry by Employee 12/3/2020: Patient's areas of skin impair to right thigh, bruise left thigh above knet A review of a "Cliet 12/7/20, evidenced revealed the DOCS to assess patient #4'.  On 1-8-2021, at 11: services verified the nothing further to accord for the nothing further to accord for the entry of the provide services all services care.  Based on record revenue all services for 2 (patients #4 and records reviewed.  The findings include 1. The clinical records (soc) 5-12-2020, was plan of care for the 11-8-2020 to 1-6-20	ent Logging Report, re" dated 12/4/20, evidenced an H "Late entry charting for s nurse called in to report 3 new ment. Patient has a new scrape to right knee, and scratch to e."  Int Logging Report" dated an entry by the DOCS which went to the home of patient #4 s injuries of unknown origin.  O5 AM, the director of nursing to above findings and had dd.  O(4)(A)  The sin plan of care the soutlined in the plan of the were adhered to by failing as ordered on the plan of care and 7) of 5 patients clinical	G 0436	All internal employees have be re-educated on the need to act to the schedule requested by patient and approved by the physician. The Administrator I completed a 100% audit of all patient schedules and completed hours, and any discrepancies been reported to the physician documented with an order.  The Administrator or Director Clinical Services will audit 100 completed patient schedules	there the  nas eted have n and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15K141	B. W	ING		01/11	/2021
		l .	Ь	STREET	ADDRESS CITY STATE 7ID COD	I	
NAME OF P	PROVIDER OR SUPPLIEF	8	STREET ADDRESS, CITY, STATE, ZIP COD  555 E COUNTY LINE ROAD SUITE 105				
TOGETH	IER HOMECARE						
IOGEIR	LITTIONICUARE			GREENWOOD, IN 46143			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	week; 9-11 hours per day for 1-2 days per week;				weekly for 5 weeks to ensure	all	
	-	ay for 1 day per week. Below			schedules remain compliant w	vith	
		nother frequency which			the plan of care. Any		
	_	t had chosen to schedule PA			discrepancies will continue to	be	
		7 hours/day x ½ days/week,			reported to the physician, and	an	
		x 1-2 days/week, and 3-5			order will be sent for		
	hours/day x 1 day p	er week.			countersignature. After 5 week	ks of	
					100% compliance, the		
	A review of the visit notes revealed visits and the				Administrator and Director will		
	•	vided for certification period			include a review of the schedu		
	11/8/20 - 1/6/20: 11/12=8h (hours), 11/13=8h,				frequency and duration during		
	11/17=8.25h, 11/18=7.75h, 11/19=8h, 11/20=8,				10% quarterly record review a	S	
	11/24=8h, 11/25=7.75h, 11/26=7.25h, 11/27=6.6h,				part of the Agency's QAPI		
		sh, 12/3=8h, 12/8=8h, 12/9=8h,			program.		
		=8h, 12/15=9.75h, 12/17=6.75h,					
		=9.75h, 12/23=9.75h,			The Administrator and Directo		
		fore, the frequency/duration			responsible for monitoring the	se	
		eet the ordered frequency and		corrective actions to ensure the			
		ed on the physician ordered			deficiency is corrected and wil	l not	
	plan of care.				recur.		
		se visit notes revealed visits					
		5-7 hours of care, 9-11 hours of					
		f care, as ordered on the plan					
		owing dates: 11-12, 11-13-20,					
		9, 11-20, 11-24, 11-25, 11-26, 12-1,					
		2-9, 12-10, 12-11, 12-17, and					
		ore, the frequency/duration					
		eet the ordered frequency and					
		ed on the physician ordered					
	plan of care.						
	2 Th1:' 1	and for motions #7 10/4/2019					
		ord for patient #7, soc 10/4/2018,					
		ontained an agency document  Certification and Plan of					
		ication period 11/22/20-1/20/21,					
		following: Medicaid PA					
		HA) [sic home health aide] 5-7					
		vs/week and 3-5 hours/day x 1					
	L DAV A WEEK, Medica	ua kesnie Program Hollre	1				•

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 01/11/2021				
	ROVIDER 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 OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
G 0484 Bldg. 00	hours/day x 1 day/w A review of the visi evidenced the follow and hours were prove for the certification were not either 5-71 (hour) 8 minutes, 12 12/4=1h, 12/7=2h, 12  On 1-8-2021, at 11: services verified the nothing further to ac  484.50(e)(1)(ii) Document complae (ii) Document both complaint and the and  Based on record revelailed to document a complaint regarding (patient #8) of 3 pat services, of a total s clinical record was a  The findings include Review of policy ere Complaint Policy," 8-21-2019, evidence Purpose To estate channeling complain for resolution, and t patient/family Co services, or charges	t notes for patient #7 wing home health aide visits yided under prior authorization period 11/22/20-1/20/21, which hours or 3-5 hours: 11/24=1h 2/1=2h, 12/2=2h, 12/4=6h, 12/8=2h, and 12/9=2h.  05 AM, the director of nursing above findings and had dd.  int and resolution the existence of the resolution of the complaint; riew and interview, the agency as a complaint, and therefor a resolution to a patient their home health aide for 1 ients with home health aide ample of 5 patients whose reviewed.	G 0484	All Agency staff members have participated in an in-service we the Administrator and Director Clinical Services to review the importance of properly documenting all complaints and dissatisfaction in the complaint and completing a thorough investigation. All staff member have acknowledged understathat any future must be communicated to the Director and/or Administrator for review direction. The complaint noted the survey report has been act to the complaint log, and the investigation has been completed. The Administrator and Director Clinical Services have completed to the parent and	w and d in dded			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		15K141	B. WING		01/11/2021	
	PROVIDER OR SUPPLIER	<b>.</b>	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	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	complaint/grievance possible to the appropossible to the approposition and a series of the steps complaint, the result of completion "  Review of the completion accomplaint patient #8.  Review of the client who received home evidenced on 12-6-does not want [name employee G] back the aide."  Review of the client evidenced on 12-8-of patient #8] to dis [name of home health accomplete with him/her. written her/him love him/her to "Move in He/she stated that he aide but feels as the overstepped [emplote On 1-8-2021 at 11:15]. Services and the adclient logging notes expressed dissatisfatheir home health accomplete the accomplete for the accom	e and forwarded as soon as opriate director or to the for investigation action and ons with a complaint will be at taken to investigate the at of the process and the date.  It of the process and the date of the process and the		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	DATE  1, with  r of utine nch and t all f nts  ram. r are se	
	no complaint was d the 2020 complaint	ocumented for patient #8 in log.				

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		X1) PROVIDER/SUPPLIER/CLIA	l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  15K141		A. BUILDING 00  B. WING			COMPLETED 01/11/2021	
		101(141	D. W	_		01/11/	12021	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10	)5		
TOGETH	IER HOMECARE			GREENWOOD, IN 46143				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	·ΤΕ	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE	
	410 IAC 17-12-3 (c	(2)						
G 0572	484.60(a)(1)							
Bldg. 00	Plan of care	receive the home health						
Diag. 00		vritten in an individualized						
		dentifies patient-specific						
	l •	mes and goals, and which						
	is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or							
her state license, certification, or registration.								
	1	rs a patient under a plan of						
		e completed until after an						
		e physician is consulted to						
		or modifications to the						
	original plan.		GO	572	All Agency nurses have been		02/12/2021	
	Based on record rev	view and interview, the agency	100	312	re-educated on the importance	e of	02/12/2021	
		gistered nurse implemented			reporting injuries of unknown			
		r to notify the physician of			to the Director of Clinical Serv	•		
	abnormal findings f	for 1 (patient #4) of 1 patient			immediately and reporting any	/		
		ntegumentary impairment and			abnormal findings to the MD in	n		
		vices were provided per the			accordance with physician ord			
		patient #4 and 7) of 5 patient			This re-education included the	<b>;</b>		
	records reviewed.				requirement to document the			
	The findings includ	ed:			detailed assessment of any w within the documentation note			
					The Agency also contacted al	I		
	_	ent #4's "Home Health			nurses to ensure there are no			
		an of Care", evidenced a start			outstanding unreported injurie			
		contained a plan of care for			unknown origin, and no furthe			
	_	iod 11/8/20-1/6/21, with orders			injuries or concerns have been	n		
	_	visits: 5-7 hours per day for 1-2 hours per day for 1-2 days per			identified.			
		s per day for 1 day per week.			The Director of Clinical Servic	200		
		cy, is another frequency which			will complete a focused audit			
	_				100% of nursing notes for the			
	indicated the patient had chosen to schedule PA hours as follows: 5-7 hours/day x ½ days/week,				mentioned in the survey repor			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 01/11/2021	
	PROVIDER OR SUPPLIEI	2	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION
140	and 9-11 hours/day hours/day x 1 day property to perform the every visit and notifindings."  A review of the visit hours that were property 11/8/20 - 1/6/20: 11/11/12-8.25h, 11/18/11/24-8h, 11/25-7/12/18-9.75h, 12/11/11/21/8-9.75h, 12/12/12/24-7.75h; there ordered failed to me hours of care ordered failed to me hours of care ordered failed to me hours of care, for the following the following the following of care ordered failed to me hours of care ordered failed to m	x 1-2 days/week, and 3-5 per week, and "SN (Skilled full, comprehensive assessment fy physician for any abnormal sit notes revealed visits and the vided for certification period 1/12=8h (hours), 11/13=8h, 12=7.75h, 11/19=8h, 11/20=8, 17.75h, 11/26=7.25h, 11/27=6.6h, 18h, 12/3=8h, 12/8=8h, 12/9=8h, 12/15=9.75h, 12/17=6.75h, 12/13=9.75h, 12/13=9.75h, 12/13=0.75h, 12/23=9.75h, fore, the frequency/duration eet the ordered frequency and ed on the physician ordered see visit notes revealed visits 5-7 hours of care, 9-11 hours of 1/2 care, as ordered on the plan owing dates: 11-12, 11-13-20, 11-20, 11-24, 11-25, 11-26, 12-1, 12-9, 12-10, 12-11, 12-17, and one, the frequency/duration eet the ordered frequency and ed on the physician ordered see the ordered frequency and ed on the physician ordered see figure." The figure intation of a scrape to the right e left knee, and a scratch to comment section stated, "Pt. to put hands between thighs visit note failed to evidence	TAG	(Employee E) for 30 days to ensure compliance with these requirements. Following 30 days of 100% compliance, the Direct of Clinical Services or RN designee will include an audit nursing notes during the Agen 10% quarterly clinical record at to ensure continued compliance.  All Agency employees have received in-service re-education regarding following the Physician ordered Plan of Care as writte Additionally, all internal employees have been re-education requirement that schedules match the frequency and dura requested by the patient and approved by the physician. The Administrator has completed at 100% audit of all patient schedules and completed hou and any discrepancies have be reported to the physician and documented with an order. The Administrator or Director of Clinical Services will audit 100 completed patient schedules weekly for 5 weeks to ensure a schedules remain compliant with plan of care. Any discrepancies will continue to reported to the physician, and order will be sent for countersignature. After 5 week 100% compliance, the Administrator and Director will include a review of the scheduling the scheduling of the scheduling the scheduling of the sch	ays ettor  of all cy's audit ce.  on ian n.  cated stion  e a rs, eeen  of w of all rith  be an as of

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the identified scrape, bruise, and scratch had been

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frequency and duration during the

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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	COMPLETED	
		15K141	B. WI	ING		01/11/	2021
	D 0.1.F.		<del></del>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			COUNTY LINE ROAD SUITE 10	)5	
TOGETH	IER HOMECARE				IWOOD, IN 46143		
(X4) ID		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	\TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+-	TAG	DEFICIENCY)		DATE
	measured and failed to evidence a descriptions of the areas where the integumentary impairments had been identified. A section titled "Physician Notified" was blank				10% quarterly record review a	as	
					part of the Agency's QAPI		
					program.		
	Notified" was blank	K.			The Administrate 15:		
	A review of a -1-:11	ad nurse visit note dated 12/2/20			The Administrator and Director		
	A review of a skilled nurse visit note dated 12/3/20 from 8 AM - 4 PM, signed by Employee E,				responsible for monitoring the corrective actions to ensure the		
					deficiency is corrected and wi		
	registered nurse, evidenced documentation of "wounds present: See figure." The figure				recur.	ii HOL	
	evidenced documentation of a scrape to the right						
	thigh, a bruise to the left knee, and a scratch to						
	_	comment section stated, "Pt					
	(sic patient) sleeps with hands tucked between						
		te failed to evidence the					
		oruise, and scratch had been					
	_	ed to evidence a descriptions of					
	the areas where the	e integumentary impairments					
		l. A section titled "Physician					
	Notified" was blank	k.					
	A review of a "Clie	ent Logging Report,					
		are" dated 12/4/20, evidenced					
		irector of clinical services					
	(DOCS,) spoke wit	th the patient's mother and due					
		out of town, a visit was					
	_	2020, to assess the identified					
	injuries of unknow	n origin.					
	A review of a "Cli	ent Logging Report,					
		are" dated 12/4/20, evidenced an					
		e H "Late entry charting for					
		t's nurse called in to report 3 new					
		rment. Patient has a new scrape					
	to right thigh, bruis	se to right knee, and scratch to					
	left thigh above kno	ee."					
		ent Logging Report" dated					
		an entry by the DOCS which					
		S went to the home of patient #4					
	to assess patient #4's injuries of unknown origin.						

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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 01/11/2021			
	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 OR The visit notes and	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION  the client logging report  dence the attending physician	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE COMPLETION		
	had been notified, a of patient #4's newl impairments of unk failed to notify the p time discovered/ide physician of the ass	s ordered on the plan of care, y identified integumentary nown origin. The agency ohysician of findings at the ntified, and failed to notify the essment findings for injuries after the investigation was					
	was reviewed and c titled "Home Health Care," for the certif which revealed the Program Hours (HI- hours/day x 3-5 day day a week; Medica	ord for patient #7, soc 10/4/2018, contained an agency document a Certification and Plan of ication period 11/22/20-1/20/21, following: Medicaid PA HA) [sic home health aide] 5-7 s/week and 3-5 hours/day x 1 did Respite Program Hours ay x 3/5 days/week and 4-6 yeek.					
	evidenced the follow and hours were pro- for the certification were not either 5-7 (hour) 8 minutes, 12 12/4=1h, 12/7=2h,	t notes for patient #7 wing home health aide visits wided under prior authorization period 11/22/20-1/20/21, which hours or 3-5 hours: 11/24=1h 2/1=2h, 12/2=2h, 12/4=6h, 12/8=2h, and 12/9=2h.					
	· ·						
G 0584	484.60(b)(3)(4) Verbal orders						

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Event ID:

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		X1) PROVIDER/SUPPLIER/CLIA				r ′	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED					
		15K141	B. WING 01/11/2021				2021	
	PROVIDER OR SUPPLIER		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	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG				TAG	DEFICIENCY)	116	DATE	
	REGULATORY OR LSC IDENTIFYING INFORMATION		G 0		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	icy, in in icers om, it int to ine		
	· ·	ions, treatments and services must be ordered by a			Manager, and all Clinical			
	physician. The orde	ers may be initiated via			Supervisors have been educa	ted		
	_	ing and must be countersigned			on the new policy.			
		a timely manner All verbal			TI D: / (0)::::0:::			
		d back" to the physician to			The Director of Clinical Servic			
		of the orders and to decrease documentation of verbal			RN designee will audit 100% o			
		nurse or therapist receives a			verbal order forms for 30 days ensure all orders are compliar			
		ne physician, he/she shall write			with Agency policy. After 30 d			
		nd then read the order back to			of 100% compliance, the Direct	-		

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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. W	NG		01/11/	/2021
				_			
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					COUNTY LINE ROAD SUITE 10	15	
TOGETH	IER HOMECARE			GREEN	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	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.16	DATE
	the physician verify	ving that the person receiving			or RN designee will review ver	rbal	
		orrectly and interpreted the			order forms as part of the		
		erbal orders are accepted by			Agency's 10% quarterly clinica	al	
	1	d agency personnel in			record audit conducted during		
		plicable state law and agency			Agency's QAPI program.		
		will be used by the agency to					
		e orders are signed and dated			The Administrator and Directo	r of	
	_	d returned to the patient's			Clinical Services are responsil		
	1	in an appropriate time frame			for monitoring these corrective		
		nent a tracking system to			actions to ensure the deficience		
	assure timely respon	— ·			corrected and will not recur.	,	
	Review of the clinic	cal record for patient #8,					
		care date of 11-5-2020, and					
	contained a plan of	care for the certification period					
	of 11-5-2020 to 1-3	-2021, with orders for home					
	health aide services	and diagnoses to include					
	Parkinson's Disease	e, diabetes mellitus, and hip					
	pain.						
	Review of the clinic	cal record evidenced a					
	document, "Physici	an Order for Re-Certification of					
	Services," with date	e of 12-30-2020, 10:57 AM,					
	written in the field	for date/time, evidenced, " Dr					
	[name of Nurse Pra	ctitioner] has been notified of					
	the assessment find	ings from the re-certification					
		2020. The physician,					
	patient/caregiver, as	nd nurse have collaborated in					
	the development an	d revision of the plan of care.					
	VERBAL ORDER:	: DISCIPLINE, FREQUENCY					
	AND DURATION	Home Health Aide 1 visit/day					
	<u>-</u>	X 8 weeks; then 1 visit/day X					
	2-4 days/week X 1 week. NO CHANGES TO THE						
	PREVIOUSLY SIGNED PLAN OF CARE, EXCEPT						
	FOR THE FOLLOWING: Patient Hospital stay						
	from 12-23 to 12-24-2020. During that						
	hospitalization the below listed medication						
	changes + below listed diagnosis were made +						
	added to (sic) his/he	er plan of care with					
	confirmation of cha	nges via hospital discharge					

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Event ID:

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Facility ID: 013867

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

PRINTED: 02/17/2021 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15K141			l í	JILDING	00	COMPL 01/11/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  555 E COUNTY LINE ROAD SUITE 105  GREENWOOD, IN 46143					
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ГЕ	(X5) COMPLETION	
TAG	paperwork. MEDIO PRESENT- SEE BI	CATION CHANGES ARE ELOW: Discontinue g @ Bedtime; Discontinue		TAG	DEFICIENCY)		DATE	
	Desmopressin 0.2 n 150 MG at bedtime DIAGNOSIS- SEE Hypo-Osmolarity + was signed by regis and dated 12-30-20	ng tablet; Begin Amitriptyline . NEW/CHANGED BELOW: E 87.1 Hyponatremia. The document tered nurse (RN), employee H, 20, at 10:57 AM. The order thad been read back, as						
	services (DOCS) in was written on 1-7-sent to patient #8's a DOCS indicated the clinician to call the speak with a design to share the finding comprehensive asseauthorization to cor comprehensive asset the plan of care for	52 AM, the director of clinical dicated the above verbal order 2021, and had not yet been attending provider. The e agency practice was for the attending provider office to ated clinician or the provider, is from the recertification essment, and request attinue services; then the essment was quality reviewed, the new certification period or on the 14th day after the						
	comprehensive asset the fully developed medication profile at then faxed to the att when queried, indice reduced to writing to the fully developed completed, and was attending provider, expiration of the profile Review of patient # evidenced an entry	essment; the verbal order and plan of care, along with the and reconciliation report, were tending provider. The DOCS, sated verbal orders were not by the receiving clinician until plan of care had been a ready to send to the up to 14 days after the evious certification period.  8's client logging notes, on 12-29-2020, "Call placed to see to [person C.] Reported						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE :	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15K141	B. WING			01/11/	2021
			<del>'</del>	STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				OUNTY LINE ROAD SUITE 10	5	
TOGETH	IER HOMECARE				WOOD, IN 46143	O	
TOOLIII	ERTIONIEOTRE			OITELIT			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		not feeling well.' Reported					
	_	from Resumption of Care					
		d[ication] changes appeared					
	to be made."						
	_	8's client logging notes,					
		on 12-30-2020, at 10:57 AM,					
	•	office and spoke to [person					
	C.] Reported assess	_					
		[recertification.] Received					
	VO [verbal order] f	or RCT [recertification.]"					
	D : 0 11	1 1 1 1 1 2 20 2020					
		order, dated 12-30-2020, at					
	10:57 AM, evidence	<del>-</del>					
	-	below medication changes and					
	_	sis were made + added to					
	-	with confirmation of changes					
	via hospital dischar						
		ANGES ARE PRESENT-SEE					
		ue Amitriptyline 25 MG at					
		ne Desmopressin 0.2 MG					
	-	iptyline 150 MG at bedtime,					
		DIAGNOSIS-SEE BELOW - E					
	87.1 Hypo-osmolari	ity + hyponatremia."					
	On 1 7 2020 at 1.2	2 PM, employee H, RN, stated					
		at date the verbal order for					
	-	obtained, indicated 12-30-2020.					
		verbal order was reduced to					
	•	employee H responded, "No."					
	-	rerbal order had been written					
		employee H replied, "Yes."					
		ontent of the verbal order					
		t of the written order based on					
		re identical, employee H					
	replied, "No."	to racinical, employee 11					
	Topfica, 140.						
	On 1-8-2021 at 11.	05 AM, the administrator and					
		cal services, verified the verbal					
		020, failed to evidence it had					
	51461 44.04 12 30-2	ozo, isilos to orisolico it ilus					

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02/17/2021 PRINTED: FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID 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 15K141 B. WING 01/11/2021 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 been read back, as required by policy, and was taken on 12-30-2020, but was reduced to writing on 1-7-2021 (8 days after the verbal order had been obtained.) The DOCS verified the verbal order documented 12-30-2020, had new information (new diagnosis resulting from hospitalization; changes in medications) which the clinician had not yet obtained on 12-30-2020, when the verbal order was taken. 410 IAC 17-14-1 (a) (1) (H) G 0588 484.60(c)(1) Reviewed, revised by physician every 60 days Bldg. 00 The individualized plan of care must be reviewed and revised by the physician who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. G 0588 The Administrator, Director of 02/05/2021 Based on record review and interview, the agency Clinical Services, and all internal failed to ensure the attending provider was clinicians have been re-educated provided a plan of care for review/revision at least about the requirement that the every 60 days, starting with the start of care date, plan of care be reviewed at least for 1 (patient #8) of 3 patients who were on every 60 days beginning with the service at least 60 days, of a sample of 5 patients. start of care date, according to federal regulations. The findings included: The Director of Clinical Services Review of the clinical record for patient #8, will review 100% of plans of care evidenced a start of care date of 11-5-2020, and for a period of 60 days to ensure contained a plan of care for the certification period all plans of care are compliant with of 11-5-2020 to 1-3-2021. this requirement. After 60 days of 100% compliance, the Director or On 11-8-2021, at 11:05 AM, the director of clinical RN designee will continue to

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services, indicated the plan of care for the 2nd

not been sent to the attending provider for

certification period which began on 1-4-2021, had

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include evaluation of the plan of

care review dates as part of the

Agency's 10% quarterly clinical

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		15K141	B. W	ING		01/11/2021	
	PROVIDER OR SUPPLIER			555 E (	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 NWOOD, IN 46143	)5	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDED'S DI AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	review/revision, and	d this represented a period of			record audit during the QAPI		
	· ·	from the start of care date of			program to ensure continued		
	11-5-2020.				compliance.		
	410 IAC 17 12 1 (a) (2)						
	410 IAC 17-13-1 (a	a) (2)			The Administrator and Directo		
					Clinical Services are responsi		
					for monitoring these corrective		
					actions to ensure the deficience	cy is	
					corrected and will not recur.		
G 0716	484.75(b)(6)						
0 07 10	Preparing clinical	notos					
Bldg. 00							
Diag. 00	Preparing clinical	notes,	C 0	716	All nurses have been re-education	otod 02/05/2021	
	Dogad on massand nor	viore and intermitary the economy	G 0	/16		02/00/2021	
		view and interview, the agency			on the requirement to docume		
		registered nurse, employee C,			the content of any education t		
	documented the pro				is provided during the provision		
		ng to the parent(s) of an infant			care, in addition to the topic of		
		on management, as ordered on			education. This item has beer	1	
	-	care, for 1 (patient #10) of 5			added to the Agency's skilled		
	patients whose clini	ical record was reviewed.			nursing competency form to		
	The findings includ	ed:			ensure that all new nurses rec the same education.	eive	
	Daview of the -1'	and managed for motion t #10			The Discoston of Official Co.		
		cal record for patient #10,			The Director of Clinical Servic		
		birth of 4-30-2019, with a start			will complete a focused audit		
		-2020, and contained a plan of			100% of nursing notes for the		
		ation period of 12-3-2020 to			mentioned in the survey repor	t	
		lers for the skilled nurse (SN)			(Employee E) for 30 days to		
	visits which include				ensure compliance with these		
		the following topics: "			requirements. Following 30 da	•	
	Medication manage	ement "			of 100% compliance, the Dire	ctor	
					of Clinical Services or RN		
		cation listed on the plan of care			designee will include an audit		
		nide Inhalation Suspension, 1			nursing notes during the Ager	· I	
	-	HALATION, 1 times every 12			10% quarterly clinical record a	audit	
	_	ess of breath]; Captopril 1 mg/1			to ensure continued complian	ce.	
	mL, 5 ml, G-tube, e	every 8 hours at 6 AM, 2 PM,					
	and 10 PM; Feeding	g mixture 180 ml, G tube, 4 times			The Administrator and Directo	or of	
	every 1 day, 1 pouc	h of Compleat Blend (10			Clinical Services are responsi		

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	COMPLE	TED	
		15K141	B. W	ING		01/11/2	2021	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	2	555 E COUNTY LINE ROAD SUITE 105					
TOGETH	IER HOMECARE		GREENWOOD, IN 46143					
	 -	OT LIBERATIVE OF STREET	1		, -		(***	
(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		of Pediasure- 4 ounces of		TAG			DATE	
	· /				for monitoring these corrective			
		divide into 4 feedings of 180 ml /ity]; Furosemide Oral Solution			actions to ensure the deficient	cy is		
		l, once a day; Keppra Oral			corrected and will not recur.			
	_	L-2 mL, Oral, Once a Day; Tap						
		G-tube, every 4 hours (each						
		dings tube patency; Albuterol						
		Nebulization Solution- 2.5 MG/3						
		INHALATION, PRN [as						
		s SOB [shortness of breath];						
		olution 10 MG/ML, 0.2 mL, Oral,						
		O NOT GIVE UNLESS						
	1	or congestion; Ibuprofen Oral						
		G / 5 ML, 100 MG/ 5 ML ORAL,						
	PRN every 6 hours	for pain/fever; Melatonin Oral						
	Liquid, 1 MG / ML	, 0.8 mL, Oral, PRN At Bedtime						
	Sleeping aide; Tyle	nol Infants Oral Suspension						
	160 MG / 5 ML, 2 I	ML, ORAL, PRN Every 6 hours						
	pain or fever.							
		prehensive assessment dated						
		oyee D, a registered nurse,						
	_	8 was less than 2 years old						
	with weight of 18 p	ounds or 8.16 Kilograms.						
	_	tered nurse visit note dated						
		loyee C, 7:45 AM to 3:45 PM,						
		ea "Education Provided" the						
	_	on provided (document details						
		of the day. Medication						
		provided to (specify						
		mily/oncoming nurse): family;						
		d understanding of education						
	provided." The visit note failed to document any							
	content of medication management education to							
	include medications covered, the specific purpose							
	of any of the ordered medications, side effects/concerns to report to the physician							
	· ·	ffects/concerns to report to the						
	agency registered n	urse, the maximum dosage of						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141			UILDING	nstruction <u>00</u>	(X3) DATE ( COMPL 01/11/	ETED	
	ROVIDER OR SUPPLIER ER HOMECARE		•	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 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)	TE	(X5) COMPLETION DATE
	Tylenol for infants, interactions/concern	and/or other possible drug ns to report.					
	12-8-2020, by empley evidenced in the are following: "Education of education) report provided to (specify patient/caregiver/fa Recipient verbalized provided." The vision content of medications of any of the ordered effects/concerns to immediately, side eagency registered in Tylenol for infants, interactions/concerns to education of education education report Review of the regis 12-9-2020, by empley evidenced in the are following: "Education patient/caregiver/fa Recipient verbalized provided." The vision content of medications of any of the ordered effects/concerns to immediately, side eagency registered in Tylenol for infants, interactions/concerns to immediately, side eagency registered in Tylenol for infants, interactions/concerns	mily/oncoming nurse): family; d understanding of education it note failed to document any on management education to a covered, the specific purpose d medications, side report to the physician offects/concerns to report to the urse, the maximum dosage of and/or other possible drug as to report.  Itered nurse visit note dated oyee C, 7:45 AM to 3:45 PM, as "Education Provided" the on provided (document details to of the day. Medication a provided to (specify mily/oncoming nurse): family; d understanding of education at note failed to document any on management education to a covered, the specific purpose d medications, side report to the physician offects/concerns to report to the urse, the maximum dosage of and/or other possible drug as to report.					
	Review of the regis	tered nurse visit note dated					

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15K141	B. WI	NG		01/11/	/2021
NAME OF F	PROVIDER OR SUPPLIEF	}			ADDRESS, CITY, STATE, ZIP COD		
					COUNTY LINE ROAD SUITE 10	5	
TOGETH	IER HOMECARE			GREEN	IWOOD, 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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		loyee C, 3:45 PM to 4:00 PM, ea "Education Provided" the					
		ion provided (document details					
	1	t of the day; Education					
	provided to (specify						
		mily/oncoming nurse): family;					
		d understanding of education					
		it note failed to document any					
	1 ^	on management education to					
		s covered, the specific purpose					
	of any of the ordere	ed medications, side					
		report to the physician					
	I -	effects/concerns to report to the					
		urse, the maximum dosage of					
		and/or other possible drug					
	interactions/concern	ns to report.					
	Review of the regis	tered nurse visit note dated					
	_	ployee C, 7:45 AM to 3:45 PM,					
		ea "Education Provided" the					
	following: "Educati	ion provided (document details					
	of education) report	t of the day. Medication					
	_	provided to (specify					
		mily/oncoming nurse): family;					
		d understanding of education					
	l ~	it note failed to document any					
		on management education to					
		s covered, the specific purpose					
	1	ed medications, side					
		report to the physician ffects/concerns to report to the					
		urse, the maximum dosage of					
	" " "	and/or other possible drug					
	interactions/concern						
		1					
	Review of the regis	tered nurse visit note dated					
		ployee C, 3:45 PM to 4:15 PM,					
		ea "Education Provided" the					
	_	ion provided (document details					
	of education) report	t of the day; Education					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	JILDING	00	COMPL	ETED
		15K141	B. W	ING		01/11/	2021
	PROVIDER OR SUPPLIER		•	555 E C	ODDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 WOOD, IN 46143	5	
TOGETHER HOMECARE				GREEN			
(X4) ID	SUMMARY	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	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	provided to (specify						
	ı .	mily/oncoming nurse): family;					
		d understanding of education					
	1 ~	it note failed to document any on management education to					
		s covered, the specific purpose					
	of any of the ordere						
	1	report to the physician					
		ffects/concerns to report to the					
	· ·	urse, the maximum dosage of					
		and/or other possible drug					
	interactions/concern						
	Review of the regis	tered nurse visit note dated					
	12-11-2020, by emp	ployee C, 8:00 AM to 3:00 PM,					
		ea "Education Provided" the					
	_	on provided (document details					
		t of the day; Education					
	provided to (specify						
		mily/oncoming nurse): family;					
		d understanding of education					
	1 ~	it note failed to document any					
		on management education to					
	of any of the ordere	s covered, the specific purpose					
		report to the physician					
		ffects/concerns to report to the					
		urse, the maximum dosage of					
		and/or other possible drug					
	interactions/concern						
	Review of the regis	tered nurse visit note dated					
	_	oloyee C, 3:00 PM to 4:30 PM,					
	evidenced in the area "Education Provided" the						
	following: "Education provided (document details						
	of education) report of the day; Education						
	provided to (specify						
	patient/caregiver/fa	mily/oncoming nurse): Family;					
		d understanding of education					
	provided." The visi	it note failed to document any					
	i		1	I			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15K141	B. WI	NG		01/11	/2021
		I .		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			COUNTY LINE ROAD SUITE 1	05	
TOGETH	IER HOMECARE				IWOOD, IN 46143		
(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 APPROPR	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ion management education to					
		s covered, the specific purpose					
		ed medications, side					
		report to the physician					
		effects/concerns to report to the					
		nurse, the maximum dosage of					
	· ·	, and/or other possible drug					
	interactions/concer	rns to report.					
	Review of the regis	stered nurse visit note dated					
		ployee C, 7:45 AM to 3:45 PM,					
		rea "Education Provided" the					
		tion provided (document details					
	_	t of the day; Education					
	provided to (specif	•					
		amily/oncoming nurse): Family;					
		ed understanding of education					
	_	sit note failed to document any					
	_	ion management education to					
		is covered, the specific purpose					
	of any of the order	ed medications, side					
	effects/concerns to	report to the physician					
	immediately, side of	effects/concerns to report to the					
	agency registered r	nurse, the maximum dosage of					
	Tylenol for infants	, and/or other possible drug					
	interactions/concer						
	Review of the regis	stered nurse visit note dated					
	_	ployee C, 3:45 PM to 5:00 PM,					
	_	rea "Education Provided" the					
		ion provided (document details					
	_	t of the day; Education					
	provided to (specif						
	patient/caregiver/family/oncoming nurse): Family;						
	Recipient verbalized understanding of education						
	provided." The visit note failed to document any						
	_	ion management education to					
		s covered, the specific purpose					
		ed medications, side					
		report to the physician					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	ILDING	00	COMPL	ETED
		15K141	B. WIN	NG		01/11/	2021
			<del>-                                    </del>	CTREET A	DDRESS CITY STATE ZIR COD		
NAME OF P	PROVIDER OR SUPPLIER	2			DDRESS, CITY, STATE, ZIP COD OUNTY LINE ROAD SUITE 10	<b>-</b>	
TOCETU						5	
IUGETH	IER HOMECARE			GREEN	WOOD, IN 46143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	I C	DATE
		ffects/concerns to report to the					
	· ·	urse, the maximum dosage of					
		and/or other possible drug					
	interactions/concern						
	interactions, concern	is to report.					
	Review of the regis	tered nurse visit note dated					
	_	ployee C, 7:45 AM to 3:45 PM,					
		ea "Education Provided" the					
		on provided (document details					
	_	t of the day; Education					
	provided to (specify	-					
		mily/oncoming nurse): Family;					
	ı .	d understanding of education					
		it note failed to document any					
	1 ~						
		on management education to					
		s covered, the specific purpose					
	of any of the ordere						
		report to the physician					
		ffects/concerns to report to the					
		urse, the maximum dosage of					
		and/or other possible drug					
	interactions/concern	ns to report.					
	_	tered nurse visit note dated					
		ployee C, 3:45 PM to 5:00 PM,					
		ea "Education Provided" the					
		on provided (document details					
	of education) report	t of the day; Education					
	provided to (specify						
		mily/oncoming nurse): Family;					
		d understanding of education					
	provided." The visi	it note failed to document any					
	content of medication	on management education to					
	include medications	s covered, the specific purpose					
of any of the ordered medications, side							
	I	report to the physician					
		ffects/concerns to report to the					
		urse, the maximum dosage of					
		and/or other possible drug					
	interactions/concern						
		1					

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

PRINTED: 02/17/2021 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15K141		A. BUILDING B. WING	00	COMPL 01/11/	ETED			
	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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO: (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
	patient #8 medications ide effects for which informed immediate chills, diarrhea, feveralle relationship informed immediate chills, diarrhea, feveralle relationship informed immediate chills, diarrhea, feveralle relationship informed immediate for possible anaphylic could occur at any tremergency medical of hives, difficulty for throat, red or purposauses blistering and required the need to physician and/or the side effects of easy swelling in feet or a and jaundice (yellow Review of the Meds Tylenol for infants to had a maximum dai pounds or 8.16 kilog day.  On 1-8-2021, at 11: related to medication the parent(s) of patient price of Clinical was inadequate door management educated which medications which medications we content of any educated the side effects, and which symptoms to	ite Drugs.com evidenced on of Budesonide had listed on the doctor may need to be elly: bruising easily, cough, or, and vomiting.  Ite Drugs.com evidenced on of Furosemide had an alert factic allergic reaction, which time, and would require help for signs and symptoms or eathing, swelling in the face pole skin rash that spreads and dipeeling.) Furosemide also report to the prescribing on home health agency nurse, bruising, unusual bleeding, inkles, diminished urination, wing of the skin or eyes.)  In a cape website evidenced ander the age of 2 years old by dosage for weight of 18 grams, of 612 mg of Tylenol per sent #8 were reviewed with the Services who confirmed there amentation of medication ion for the parent(s) of patient motes above failed to evidence were addressed, and the ation of the intended effect, interactions of medications, call for emergency and/or or maximum dosages.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) D.		(X3) DATE	) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15K141	B. W	B. WING		01/11	/2021
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			COUNTY LINE ROAD SUITE 10	15	
TOGETH	IER HOMECARE				NWOOD, IN 46143	.0	
100211	T TOWNE OF WILE				1		1
(X4) ID		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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	410 IAC 17-14-1 (	a) (1) (E)					
0.740	404 75(1)(7)						
G 0718	484.75(b)(7)						
Dida 00	Communication v						
Bldg. 00		with all physicians involved in					
		and other health care					
		appropriate) related to the					
	current plan of ca	are;		710	All A b b		02/05/2021
	Događan masand na	view, the agency failed to	G 0	/18	All Agency nurses have been	f	02/05/2021
		ed nurse notified the physician			re-educated on the importance		
	_	umentary impairment for 1			reporting injuries of unknown of to the Director of Clinical Serv	-	
	(patient #4) of 5 pa						
	(patient #4) of 5 pa	atients.			and physician immediately. The	IIS	
	Findings include:				re-education included the	001/	
	rindings include.				requirements for documenting	-	
	The clinical record	for patient #4, start of care			wound, including measuremen		
		a "Home Health Certification			and full description of the wou and peri-wound area. All nurse		
		for the certification period			have acknowledged understar		
		nich revealed an order stating,			of this in-service material.	luling	
		e) to perform full, comprehensive			of this in-service material.		
		visit and notify physician for			The Director of Clinical Servic	ec or	
	any abnormal findi				RN designee will complete a	C3 UI	
	any aonormai inidi	ings.			focused audit of 100% of nurs	ina	
	A review of a skill	ed nurse visit note for patient			notes for the RN mentioned in	-	
		from 8 AM- 4 PM, signed by			survey report (Employee E) for		
	·	nentation of "wounds present:			days to ensure compliance wi		
		gure evidenced a scrape to the			these requirements. Following		
		e to the left knee, and a scratch			days of 100% compliance, the		
		The comment section stated, "Pt.			Director of Clinical Services or		
	_	to put hands between thighs			designee will include an audit		
		e visit noted failed to evidence			nursing notes during the Agen		
	_	lescriptions of the areas			10% quarterly clinical record a	-	
		areas titled, "Physician			to ensure continued compliance		
	Notified" was blan	•			l	• •	
					The Administrator and Directo	r of	
	A review of a skill	ed nurse visit note for patient			Clinical Services are responsi		
		from 8 AM - 4 PM, signed by			for monitoring the corrective		
	·	enced documentation of			actions to ensure the deficience	cy is	
		See figure." The figure			corrected and will not recur.	,	

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	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 01/11/2021			
	PROVIDER OR SUPPLIEF	8	555 E	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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
me	evidenced a scrape the left knee, and a comment section st tucked between leg evidence measurem areas included in th "Physician Notified  The registered nurs the plan of care ord findings at the time to notify the physic for injuries of unkn investigation was co	to the right thigh, a bruise to scratch to the left thigh. The ated, "Pt sleeps with hands s." The visit note failed to tents or descriptions of the e assessment. A section titled "was blank.  e, employee E, failed to follow er to notify the physician of they were identified and failed ian of the assessment findings own origin after the agency ompleted,  05 AM, the director of nursing e above findings and had dd.						
G 0802	484.80(g)(3)							
Bldg. 00	(i) The provision of (ii) The performant an extension of the (iii) Assistance in a	ome health aide include:  If hands-on personal care; ce of simple procedures as erapy or nursing services; ambulation or exercises;  administering medications						
	Based on record rev failed to ensure hor care tasks included on care, the perforn an extension of nur- ambulation or exerc	view and interview, the agency ne health aide (HHA) assigned only the provision of hands nance of simple procedures as sing services, assistance in cises, and assistance with cations which were ordinarily	G 0802	All internal staff members have participated in an in-service regarding hands-on personal contasks on the Medicaid PA care plan, and the requirement to liminal tasks that do not involve hands-on personal care, include housekeeping, to the waiver ai	are mit ding			

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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  01/11/2021	
	PROVIDER OR SUPPLIER		555 E	T ADDRESS, CITY, STATE, ZIP COD E COUNTY LINE ROAD SUITE 1 ENWOOD, IN 46143	105
(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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
ing	self-administered, f with home health ai 5 patients.	or 1 of 3 (patients #8) patients de services, out of a sample of	ind	care plan. All PA care plans been revised with all non-per care tasks removed. All reco are now 100% compliant with requirement.	have rsonal rds
	Review of the plan of care for patient #8 evidenced a start of care date of 11-5-2020, and contained a plan of care for the certification period of 11-5-2020 to 1-3-2021, with orders for HHA services under prior authorization 1-2 hours per visit, 3-5 times per week, and home health aide under waiver services 5.5 to 7.5 hours per visit, for 3-5 days per week; both for 8 weeks duration. The plan of care HHA orders evidenced " change bed linens; weekly and PRN [as needed] PA/W [prior authorization and waiver]; take out trash PRN, PA/W; clean bathrooms every visit; PA/W; Light housekeeping every visit; PA/W; Assist with Laundry every visit; PA/W; Assist with dishes: including wiping down stove, counters, and table; Every visit; PA/W; Make bed Every visit; PA/W; Mop Floor Kitchen Weekly and PRN - EOD [end of day]; PA/W; Vacuum/Sweep Weekly and PRN - EOD; PA/W; Dust Every visit; PA/W "			The Director of Clinical Servi will audit 100% of new PA ai care plans for a period of 60 to ensure they are 100% compliant with the federal requirement at CFR484.80 (After 60 days, The Director of Clinical Services or RN design will include aide care plans in 10% clinical record audit dur the Agency's quarterly QAPI program.  The Administrator and Direct Clinical Services are responsifor monitoring these correctivactions to ensure the deficient corrected and will not recur.	de days  g)(3).  of gnee n the ing  tor of sible ve
	evidenced the dutie bowel movement if medication reminde handling (no admin with ambulation/tra cane/walker- PRN; visit; Laundry every stove, table, every v and PRN; Make be housekeeping every bathroom every visit	care plan, dated 12-30-2020, s for the HHA: "document greater than 3 days- PRN; or every visit; medication istration) every visit; assist insfers every visit; use of prepare/serve meals every visit; Dishes, counters, risit; Sweep/Vacuum weekly devery visit; Light visit; dust every visit, mop it; mop kitchen weekly and m every visit; change linens			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/11/2021	
	ROVIDER OR SUPPLIER ER HOMECARE		555 E	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 NWOOD, IN 46143	05
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR weekly and PRN; T and Waiver services	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION  rash removal PRN; for both PA  s. Waiver services plan of	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	The HHA prior auth duties which were n care, the performan- extension of nursing ambulation or exerc administering medic self-administered, to weekly, light house visit, and mop baths instructed to be pro- related, and inciden hands-on care	transportation/errands PRN. norization care plan evidenced not the provision of hands on ce of simple procedures as an g services, assistance in rises, and assistance with cations which were ordinarily to include sweeping/vacuuming keeping every visit, dust every room every visit and were not wided only if necessary, tal to the provision of			
	1-5-2021, evidenced other than the proviperformance of simple of nursing services, exercises, and assist medications which self-administered (slight housekeeping mop bathroom ever 11-13, 11-16, 11-18 11-25, 11-27, 11-28 12-8, 12-9, 12-10, 1	ait notes from 11-11-2020 to d the HHA had performed tasks sion of hands on care, the ple procedures as an extension assistance in ambulation or tance with administering were ordinarily weeping/vacuuming weekly, every visit, dust every visit, y visit) on 11-11-2020, 11-12, 11-19, 11-20, 11-23, 11-24, 11-30, 12-1, 12-2, 12-3, 12-4, 2-11, 12-14, 12-15, 12-16, 12-17, 11-23-2020, 1-4-2021, and			
	the director of clinic all the assigned HH authorization servic not all the assigned hands-on direct pati	25 AM, the administrator and cal services indicated believing A duties for prior es were appropriate, although duties were the provision of ent care or incidental to of direct hands on care			

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AND PLAN OF CORRECTION IDENT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 01/11/2021	
	PROVIDER OR SUPPLIED HER HOMECARE SUMMARY	R STATEMENT OF DEFICIENCIE		555 E (	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE 10 NWOOD, IN 46143	)5	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION (1-13)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION DATE
G 0942 Bldg. 00	484.105(a) Governing body Standard: Gover A governing body functioning) must and responsibility management and all home health so review of the age operational plans and performance  Based on record re governing body fai legal authority and health agency to in revised a policy, "F defined time limit to orders with physici policies reviewed.  The findings include Review of a policy reviewed/revised o stated, "All medica provided to patient physician. The ord telephone or in wri by the physician in policy failed to esta what constituted a  On 1-8-2021, at 11 services (DOCS) in significant changes the expectation was	ning body.  (or designated persons so assume full legal authority for the agency's overall legal persons of ervices, fiscal operations, ncy's budget and its, and its quality assessment improvement program.  view and interview, the led to ensure it exercised full responsibility for the home clude having reviewed and Physician Orders" to include a for the return of physician an authentication for 1 of 7  ded:  "Physician Orders," last in 8-21-19, evidenced the policy tions, treatments and services is must be ordered by a lers may be initiated via ting and must be countersigned a timely manner " The ablish an objective timeline for	G 09	942	The Agency, in collaboration of the Governing Body, has revise the Agency's Physician Order policy, C-635, to reflect the language in the Conditions of Participation, and has included requirement that all Physician orders be signed by the Physician orders be signed by the Physician orders be signed by the Physician orders have been educated and The Administrator, Director, Branch Manager, and all Clinical Supervisors have been educated on the new policy.  The Director of Clinical Service RN designee will audit 100% of physician orders for 30 days to the ensure all orders are compliant with Agency policy - C-635. At 30 days of 100% compliance, Director or RN designee will reverbal order forms as part of the Agency's 10% quarterly clinical record audit conducted during Agency's QAPI program.  The Administrator and Director the service of the Administrator and Director or RN designee.	d the cian te. cal ted es or of o nt fter the eview he al the	02/05/2021

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED	
		15K141		B. WING			01/11/2021	
				_	_			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	_		
T005T1				555 E COUNTY LINE ROAD SUITE 105				
IOGETH	ER HOMECARE			GREEN	IWOOD, IN 46143			
(X4) ID	SUMMARY S	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			rc	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	· C	DATE	
	same or next day. F	For other orders, the			Clinical Services are responsib	ole		
	expectation was the	orders should be in the			for monitoring these corrective			
	_	days. The DOCS verified the			actions to ensure the deficienc			
		lish the timeframe for return of			corrected and will not recur.	,		
		ated written and verbal orders.						
	1 3							
	410 IAC 17-12-1 (t	o)						
		,						
G 0948	484.105(b)(1)(ii)							
		l day-to-day operations						
Bldg. 00	(ii) Be responsible							
	operations of the I	HHA;						
			G 0	948	The Administrator has participa	ated	02/05/2021	
	Based on record rev	riew and interview, the			in and has had direct oversigh			
	administrator failed	to ensure the registered nurse			all in-services and activities re			
	reported injuries of	an unknown origin to the			to the Agency's corrective acti			
		immediately for 1 (patient #4)						
	of 1 patient with an	identified integumentary			The Administrator will include			
	impairment; failed t	o ensure patients rights were			validation of the continued			
	adhered to by failing	g to provide services as			corrective actions in the weekl	у		
	ordered on the plan	of care for 2 (patients #4 and			meeting with the Clinical Direc	-		
	7) of 5 patients clini	ical records reviewed; failed to			The Administrator will continue	e to		
	ensure a registered i	nurse implemented the			be responsible for the day-to-c	lay		
	physician's order to	notify the physician of			operations by overseeing and			
	abnormal findings f	or 1 (patient #4) of 1 patient			reporting the Agency's correct	ive		
	with an identified in	tegumentary impairment and			action monitoring results to the	9		
	failed to ensure serv	rices were provided per the			Governing Body at the end of	the		
	plan of care for 2 (p	atient #4 and 7) of 5 patient			established monitoring periods	6		
	records reviewed; fa	ailed to ensure the registered			and quarterly thereafter, as pa	rt of		
	nurse followed ager	ncy policy in relation to taking			the Agency's QAPI program.			
	of a telephone order	for 1 (Patient #8) of 5 patients						
	whose clinical recor	d was reviewed; failed to			The Administrator is responsib	le		
	ensure the attending	provider was provided a plan			for monitoring the corrective			
		evision at least every 60 days,			actions to ensure the deficienc	;y		
		rt of care date, for 1 (patient			does not recur.			
		o were on service at least 60						
		5 patients; failed to ensure						
		, employee C, documented the						
		on/counseling to the						
		nt related to medication						
			1		I			

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K141		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/11/2021	
	PROVIDER OR SUPPLIER	2	555 E	ADDRESS, CITY, STATE, ZIP COD COUNTY LINE ROAD SUITE NWOOD, IN 46143	105
(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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION COMPLETION
	care, for 1 (patient a clinical record was home health aide (Fincluded only the properformance of sim of nursing services, exercises, and assis medications which self-administered, for the alth aide services for 1 of 1 home heat. The findings included The administrator for the properties of the prop	or 2 of 3 patients with home, out of a sample of 5 patients, lth agency administrator.  ed:  ailed to ensure the registered ies of an unknown origin to ical Services immediately. (See ailed to ensure patients rights failing to provide services as of care. (See G 436)  ailed to to ensure a complaint documented with resolution.  ailed to ensure a registered the physician's order to notify normal findings and failed to e provided per the plan of			

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provider was provided a plan of care for

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039			
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED 01/11/2021			
		15K141	B. WING					
			<u> </u>	_				
NAME OF F	PROVIDER OR SUPPLIER	R		ADDRESS, CITY, STATE, ZIP COD				
01 1	no vident on borreie.			555 E COUNTY LINE ROAD SUITE 105				
TOGETH	IER HOMECARE		GREE	GREENWOOD, IN 46143				
(X4) ID	SHWWARV	STATEMENT OF DEFICIENCIE	ID		(X5)			
PREFIX				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE				
		NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE!	DATE			
		least every 60 days, starting						
	with the start of car	re date. (See G 588)						
		failed to ensure the registered						
	nurse, employee C,	documented the provision of						
	education/counselin	ng to the parent(s) of an infant						
	related to medication	on management, as ordered on						
	the medical plan of	care. (See G 716)						
	_	· · · ·						
	The administrator f	failed to ensure home health						
		ed care tasks included only the						
	, , ,	on care, the performance of						
	_	as an extension of nursing						
		e in ambulation or exercises,						
		administering medications						
		rily self-administered. (See G						
	802)							
	410 14 C 17 12 1 (	-) (1)						
	410 IAC 17-12-1 (d	c) (1)						
G 0964	404 405(-)(0)							
G 0904	484.105(c)(3)							
DI 1 00	Coordinate referra							
Bldg. 00	Coordinating refe	rrals,						
			G 0964	The Administrator, Director of				
		view and interview, the director		Clinical Services, and all inter				
		failed to ensure a referral was		clinicians have been educated	J on			
		inated for an evaluation for the		the requirement to continually				
	appropriateness of	physical therapy services for 1		assess the changing needs of	·			
		tient with multiple falls, hip		patients, including the need for	ır			
	pain, shoulder arthr	ritis, and diagnosis of		any therapy services, and to s	eek			
		e, out of a total sample of 5		referrals from the Physician w				
	patients.	_		the assessing nurse determine				
	_			that a therapy consult may be				
	The findings includ	led:		needed. This education also				
	87144			included a new process to				
	Review of the job of	description for Director of		specifically target patients with	,			
		DOCS), signed by the DOCS on		multiple falls. A section has be				
	· ·	eed under "Essential		added to all Agency assessment				
		Accountability" the DOCS " 1		forms to remind the assessing				

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Plans, directs, coordinates and monitors the

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nurse that any clinical indication

If continuation sheet

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		X1) PROVIDER/SUPPLIER/CLIA	· /	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		15K141	B. WI	NG		01/11/2021	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	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	(X.5	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DAT	E
		t and indirect services to			for therapy, whether speech,		
		clients Identifies systems			occupational, physical, or		
	to recognize client needs, respond to client needs, respond to client needs, and to measure the outcome of Agency interventions "				otherwise, must be reported to		
					Physician, and therapy referra	1/	
					consult must be requested.		
	B	1.0			Additionally, all patient falls wi	l be	
		cal record for patient #8,			entered into a new tracker		
	evidenced a start of care date of 11-5-2020, and				overseen by the Director, and	-	
	_	care for the certification period			patient with a fall frequency th		
		, with orders for home health			exceeds the Agency's thresho		
	aide services, and d	_			will be contacted by the Direct	or	
		e, Diabetes Mellitus, and hip			or RN designee to discuss a		
		are evidenced patient #8 had a			referral to Physical Therapy. T	he	
		2 weeks prior to admission, and			supervising Physician will be		
	had a cane and rolla	ntor which did not reduce falls.			notified of the fall prevalence,	and	
					a therapy consult will be		
		t logging dated 11-16-2020,			requested.		
		caregiver out at [name of				_	
	-	l us that [name of patient 8]			The Administrator and Director	r of	
		yesterday. Paramedics were			Clinical Services will audit the		
		e was able to get seen by a			agency's fall log and new fall		
	doctor this morning	ş."			tracker for 100% of falls for the	•	
					next 60 days to ensure		
		cal record evidenced an X-ray			compliance with this new proc		
	_	2020, "INDICATION: pain in			The Director or RN designee	vill	
		IPRESSION: Arthritic changes			audit 100% of completed		
		ere is AC [acromial-clavicular]			assessments for 60 days to		
		ative disc disease] with bony			ensure any assessment findin	-	
	hypertrophy and so	ft tissue fullness "			that indicate a need for any ty		
	0.160001.5-	0.704			therapy, along with subsequer		
		0 PM, when queried if a physical			request to MD for therapy refe	rral,	
		had been considered and a			is documented in the clinical		
		for patient #8, indicated there			record. After 60 days, the Dire		
		the clinical record the			will continue to monitor the fal	log	
		N) case manager, employee H,			and tracker weekly to ensure		
	_	r patient #8 after multiple			continued compliance, and the		
		h diagnosis of Parkinson's			comprehensive assessments		
	Disease.				continue to be monitored as p		
					of the Agency's 10% quarterly		
	On 1-7-2021, at 1:3	2 PM, during a telephone			record review. The continued		

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU B. WI		00	COMPLETED 01/11/2021	
		15K141	B. WI	NG		01/11/	72021
NAME OF 1	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	_	
TOCETL					COUNTY LINE ROAD SUITE 10	15	
TOGETA	HER HOMECARE			GREEI	NWOOD, IN 46143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION CONTROL OF A CALL CORRECTIVE A CATION SHOULD BE			(X5)
PREFIX	-	NCY 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			DATE
		, employee H, when queried if ordinating with the DOCS for a			compliance for the assessmen	IIS	
	referral for a physical therapy evaluation				and fall log / fall tracker will audited and resulted in the		
	patient #8, replied,				Agency's quarterly QAPI prog	ram	
	patient #6, replied,	110.			report.	aiii	
	On 1-8-2021, at 11	:05 AM, the director of clinical			Toport.		
		ministrator indicated having			The Administrator and Directo	r of	
		s for patient evaluations, and			Clinical Services are responsi		
	for treatment when	-			for monitoring these corrective		
					actions to ensure the deficience	cy is	
		nterview on 1-11-2021, at 3:21			corrected and will not recur.		
PM, person B, Certified Medical Assistant for person D, Nurse Practitioner for patient #8,							
	indicated after having spoken to person D, pati						
	_	osis of Parkinson's disease and					
		multiple falls, would benefit					
		erapy (PT) evaluation, and PT					
		nent plan was recommended by					
		sist. Person B indicated person					
		health agency had not					
		al therapy evaluation for B indicated person D stated					
	_	neurologist and orthopedic					
	_	have input into the nature of					
	physical therapy se	-					
	F,						
	410 IAC 17-14-1 (	a) (1) (F)					
G 0966	484.105(c)(4)						
		eeds are continually					
Bldg. 00	assessed						
	Assuring that pat	ient needs are continually					
	assessed, and	Ţ					
			G 0	966	The Administrator, Director of		02/12/2021
		view and interview, the director			Clinical Services, and all inter	nal	
		failed to ensure a patient's			clinicians have been educated	l on	
		ally assessed in relation to a			the importance of continually		
		le falls, diagnoses to include			assessing the changing needs		
		e, hip pain, shoulder arthritis,			patients, including the need for		
I	and recent acute ca	re hospitalization, for the need	I		physical, occupational, speecl	າ, or	I

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	
		15K141	B. WING 01/11/2021			2021	
NAME OF I	DDOVIDED OD CLIDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIEF	<b>T</b>	555 E COUNTY LINE ROAD SUITE 105				
TOGETH	HER HOMECARE			GREEN	NWOOD, IN 46143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION SHOULD BE			(X5)
PREFIX		ICY 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
		cal therapy evaluation for 1			other therapy services, and the	ie	
		tient with multiple falls, hip			requirement to seek therapy		
	_	ritis, and use of assistive			referrals or consults from the		
		not prevent falls, out of a total			Physician when the assessing		
	sample of 5 patients	S.			nurse determines that therapy	/	
	The findings includ	led:			may be indicated.		
	Review of the job description for Director of Clinical Services (DOCS), signed by the DOCS on				The Director or RN designee	will	
					complete a focused audit of 1	I .	
					of completed comprehensive		
	8-21-2019, evidenced under "Essential				assessments for 60 days to		
	functions/Areas of Accountability" the DOCS " 1.				ensure any assessment findir	ngs	
	Plans, directs, coordinates and monitors the				that indicate a need for any ty	pe of	
	delivery of all direct and indirect services to				therapy, along with subseque	nt	
	Agency home care	clients Identifies systems			request to MD for therapy refe	erral,	
	to recognize client	needs, respond to client needs,			are documented in the clinica	ı	
	respond to client ne	eeds, and to measure the			record. Following the 60-day		
	outcome of Agency	interventions "			monitoring period, all		
					comprehensive assessments	will	
		cal record for patient #8,			continue to be monitored as p	art	
		care date of 11-5-2020, and			of the Agency's 10% quarterly	/	
	_	care for the certification period			record review to ensure contin	nued	
		, with orders for home health			compliance.		
		liagnoses to include					
		, Diabetes Mellitus, and hip			The Administrator and Director		
		are evidenced patient #8 had a			Clinical Services are responsi		
		2 weeks prior to admission, and			for monitoring these corrective	I .	
	had a cane and rolla	ator which did not reduce falls.			actions to ensure the deficien	cy is	
	Review of the clien	t logging dated 11-16-2020,			corrected and will not recur.		
		caregiver out at [name of					
		us that [name of patient 8]					
	* '-	yesterday. Paramedics were					
		e was able to get seen by a					
	doctor this morning	-					
	actor this morning	··					
		cal record evidenced an X-ray					
	_	2020, "INDICATION: pain in					
	_	IPRESSION: Arthritic changes					
	DISCUSSION: The	ere is AC [acromial-clavicular]					

	IT OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED 01/11/2021		
	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 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
		ative disc disease] with bony ft tissue fullness "					
	resumption of care, comprehensive asso evidenced patient #	ehensive assessment for dated 12-28-2020, and a essment dated 12-30-2020, 8 had gone to the emergency are hospital, and was kept					
	12-24-2020, eviden 12-23-2020, for int	al discharge summary, dated admission date of ravenous therapy for blood sodium) and discharged					
	therapy evaluation recent reported falls the director of clini no documentation i registered nurse (R	0 PM, when queried if a physical had been considered after s and patient #8's diagnoses, cal services indicated there was n the clinical record the N) case manager, employee H, ferrals for patient #8.					
	interview with RN, had considered coo	2 PM, during a telephone employee H, when queried if rdinating with the DOCS for a cal therapy evaluation for "No."					
	services and the ada	205 AM, the director of clinical ministrator indicated having for patient evaluations, and when appropriate.					
	PM, person B, Cert person D, Nurse Pr indicated after havi	nterview on 1-11-2021, at 3:21 ified Medical Assistant for actitioner for patient #8, ng spoken to person D, patient osis of Parkinson's disease and					

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

PRINTED: 02/17/2021 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K141	ì í	JILDING	ONSTRUCTION  00	(X3) DATE COMPI 01/11	LETED
NAME OF PROVIDER OR SUPPLIER TOGETHER HOMECARE			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	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	patient's history of multiple falls, would benefit from a physical therapy (PT) evaluation, and PT services, if a treatment plan was recommended by the physical therapist.  Person B indicated person D stated the home health agency had not requested a physical therapy evaluation for patient #8. Person B indicated person D stated patient #8 also had neurologist and orthopedic providers who may have input into the nature of physical therapy services.  410 IAC 17- 14- 1 (a) (1) (F)						

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