STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K141	A. BUILDING 00 B. WING	01/11/2021

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

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0000 Bldg. 00	This visit was for a post condition revisit survey of a Medicaid Home Health Agency. The original complaint survey, IN 00307172; was substantiated with related and unrelated findings, and resulted in a full extended survey, with a date of exit of 9-18-2020. Survey Dates: 1-5, 1-6, 1-7, 1-8, and for return phone call from attending provider, 1-11-2021 Facility #: 013867 CCN: 15K141 During this survey, exit date of 1-11-2021, 4 Condition level deficiencies were corrected; 16 standard level deficiencies were corrected; 7 standard level deficiencies were re-cited; and 5 new standard level deficiencies were cited. Based on the Condition-level deficiencies identified during the 9-18-2020, survey, your home health agency was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act, on 9-9-2020 at 1:45 P.M.; for the following condition level deficiencies: Patient Rights, 42 CFR 484.50; Care Planning, Coordination and Quality of Care, 42 CFR 484.60; Quality Assessment/Performance Improvement 42 CFR 484.65; and Organization and Administration of Services, 42 CFR 484.105. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training and/or competency evaluation programs for two years	G 0000	**Together Homecare ("Together") submits the following Plan of Correction as required by State and Federal law. Together's submission of this Plan of Correction should not be taken as an agreement with or admission of any of the findings contained therein. Together hereby expressly reserves the right to challenge the factual findings, legal conclusions, and allegations contained in the underlying reports.** **Compliance has been and will be achieved no later than the last completion date identified 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 TITLE (X6) DATE

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	beginning 9-18-2020, and continuing through 9-17-2022. 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 Bldg. 00	484.50(c)(2) Be free from abuse Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property; Based on record review and interview, the agency failed to ensure the registered nurse reported injuries of an unknown origin to the Director of Nursing immediately for 1 (patient #4) of 1 patient with an identified integumentary impairment, of a total sample of 5 patients. The findings included: 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 compliance by 11/24/20, in regards to the investigation of injuries of unknown origin. The plan of correction revealed " ... All employees were re-educated on patient rights, including the right to be free from all abuse, injuries of unknown origin ... To ensure that the Agency's investigative process is thorough and clear .... " The clinical record of patient #4, Start of Care 5/12/20, was reviewed and contained a "Home Health Certification and Plan of Care" for the certification period 11/8/20-1/6/21, with orders for	G 0430	All Agency nurses have been re-educated on the importance of reporting injuries of unknown origin to the Director of Clinical Services immediately so that the Director can complete an assessment and begin an investigation. Additionally, all nurses have been re-educated on the process for documenting any wound, including measurement and full description of the area. All nurses have acknowledged understanding of this in-service material. The Agency contacted all nurses to ensure there are no outstanding unreported injuries of unknown origin, and no further injuries or concerns have been identified at this time. The Director of Clinical Services or RN designee will complete a focused audit of 100% of nursing notes for the RN mentioned in the	02/05/2021

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	skilled nursing. A review of a skilled nurse visit note dated 12/2/20 from 8 AM- 4 PM, signed by Employee E, registered nurse, revealed documentation of "wounds present: see figure." The figure revealed documentation of a scrape to the right thigh, a bruise to the left knee, and a scratch to the left thigh. The comment section stated, "Pt. (sic patient) tends to put hands between thighs while asleep." The visit note failed to evidence the identified scrape, bruise, and scratch had been measured and failed to evidence a descriptions of the areas where the integumentary impairments had been identified and failed to evidence that the Director of Clinical Services (DOCS) had been notified of the injuries of unknown origin immediately. A review of a skilled nurse visit note dated 12/3/20 from 8 AM - 4 PM, signed by Employee E , registered nurse, revealed documentation of "wounds present: See figure." The figure revealed documentation of a scrape to the right thigh, a bruise to the left knee, and a scratch to the left thigh. The comment section stated, "Pt (sic patient) sleeps with hands tucked between legs." The visit note failed to evidence the identified scrape, bruise, and scratch had been measured and failed to evidence a descriptions of the areas where the integumentary impairments had been identified and failed to evidence that the DOCS had been notified of the injuries of unknown origin immediately. A review of a "Client Logging Report, Coordination of Care" dated 12/4/20, evidenced Employee B, the DOCS, spoke with the patient's mother and due to the family being out of town, a visit was arranged for 12/7/2020, to assess the		survey report (Employee E) for 30 days to ensure compliance with these requirements. Following 30 days of 100% compliance, the Director of Clinical Services or RN designee will include an audit of nursing notes during the Agency's 10% quarterly clinical record audit to ensure continued compliance. The Director of Clinical Services and Administrator are responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur	

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	identified injuries of unknown origin. A review of a "Client Logging Report, Coordination of Care" dated 12/4/20, evidenced an entry by Employee H "Late entry charting for 12/3/2020: Patient's nurse called in to report 3 new areas of skin impairment. Patient has a new scrape to right thigh, bruise to right knee, and scratch to left thigh above knee." A review of a "Client Logging Report" dated 12/7/20, evidenced an entry by the DOCS which revealed the DOCS went to the home of patient #4 to assess patient #4's injuries of unknown origin. On 1-8-2021, at 11:05 AM, the director of nursing services verified the above findings and had nothing further to add. 410 IAC 17-12-3 (b)(4)(A)			
G 0436 Bldg. 00	484.50(c)(5) Receive all services in plan of care Receive all services outlined in the plan of care. Based on record review, the agency failed to ensure patients rights were adhered to by failing to provide services as ordered on the plan of care for 2 (patients #4 and 7) of 5 patients clinical records reviewed. The findings included: 1. The clinical record for patient #4, start of care (soc) 5-12-2020, was reviewed and contained a plan of care for the certification period of 11-8-2020 to 1-6-2021, with orders for skilled nursing visits: 5-7 hours per day for 1-2 days per	G 0436	All internal employees have been re-educated on the need to adhere to the schedule requested by the patient and approved by the physician. The Administrator has completed a 100% audit of all patient schedules and completed hours, and any discrepancies have been reported to the physician and documented with an order. The Administrator or Director of Clinical Services will audit 100% of completed patient schedules	02/05/2021

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	week; 9-11 hours per day for 1-2 days per week; and 3-5 hours per day for 1 day per week. Below said frequency, is another frequency which indicated the patient had chosen to schedule PA hours as follows: 5-7 hours/day x ½ days/week, and 9-11 hours/day x 1-2 days/week, and 3-5 hours/day x 1 day per week. A review of the visit notes revealed visits and the hours that were provided for certification period 11/8/20 - 1/6/20: 11/12=8h (hours), 11/13=8h, 11/17=8.25h, 11/18=7.75h, 11/19=8h, 11/20=8, 11/24=8h, 11/25=7.75h, 11/26=7.25h, 11/27=6.6h, 12/1=8.25h, 12/2=8h, 12/3=8h, 12/8=8h, 12/9=8h, 12/10=7.75h, 12/11=8h, 12/15=9.75h, 12/17=6.75h, 12/18=9.75h, 12/22=9.75h, 12/23=9.75h, 12/24=7.75h; therefore, the frequency/duration ordered failed to meet the ordered frequency and hours of care ordered on the physician ordered plan of care. A review of the nurse visit notes revealed visits which were neither 5-7 hours of care, 9-11 hours of care, or 3-5 hours of care, as ordered on the plan of care, for the following dates: 11-12, 11-13-20, 11-17, 11-18, 11-19, 11-20, 11-24, 11-25, 11-26, 12-1, 12-2, 12-3, 12-8, 12-9, 12-10, 12-11, 12-17, and 12-24-2020; therefore, the frequency/duration ordered failed to meet the ordered frequency and hours of care ordered on the physician ordered plan of care. 2. The clinical record for patient #7, soc 10/4/2018, was reviewed and contained an agency document titled "Home Health Certification and Plan of Care," for the certification period 11/22/20-1/20/21, which revealed the following: Medicaid PA Program Hours (HHA) [sic home health aide] 5-7 hours/day x 3-5 days/week and 3-5 hours/day x 1 day a week; Medicaid Respite Program Hours		weekly for 5 weeks to ensure all schedules remain compliant with the plan of care. Any discrepancies will continue to be reported to the physician, and an order will be sent for countersignature. After 5 weeks of 100% compliance, the Administrator and Director will include a review of the schedule frequency and duration during the 10% quarterly record review as part of the Agency's QAPI program. The Administrator and Director are responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	

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	(HHA), 1-3 hours/day x 3/5 days/week and 4-6 hours/day x 1 day/week. A review of the visit notes for patient #7 evidenced the following home health aide visits and hours were provided under prior authorization for the certification period 11/22/20-1/20/21, which were not either 5-7 hours or 3-5 hours: 11/24=1h (hour) 8 minutes, 12/1=2h, 12/2=2h, 12/4=6h, 12/4=1h, 12/7=2h, 12/8=2h, and 12/9=2h. On 1-8-2021, at 11:05 AM, the director of nursing services verified the above findings and had nothing further to add.			
G 0484 Bldg. 00	484.50(e)(1)(ii) Document complaint and resolution (ii) Document both the existence of the complaint and the resolution of the complaint; and Based on record review and interview, the agency failed to recognize as a complaint, and therefor failed to document a resolution to a patient complaint regarding their home health aide for 1 (patient #8) of 3 patients with home health aide services, of a total sample of 5 patients whose clinical record was reviewed. The findings included: Review of policy entitled "Patient/Family Complaint Policy," last reviewed/revised 8-21-2019, evidenced the policy stated, " ... Purpose ... To establish a procedure for channeling complaints to the appropriate person for resolution, and to provide a response to the patient/family ... Complaints regarding treatment, services, or charges will be documented on the grievance form by the person receiving the	G 0484	All Agency staff members have participated in an in-service with the Administrator and Director of Clinical Services to review the importance of properly documenting all complaints and dissatisfaction in the complaint log and completing a thorough investigation. All staff members have acknowledged understanding that any future must be communicated to the Director and/or Administrator for review and direction. The complaint noted in the survey report has been added to the complaint log, and the investigation has been completed. The Administrator and Director of Clinical Services have completed a 100% audit of the parent and	02/12/2021

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	complaint/grievance and forwarded as soon as possible to the appropriate director or to the management team for investigation action and trending ... All persons with a complaint will be notified of the steps taken to investigate the complaint, the result of the process and the date of completion ... " Review of the complaint log for 2020 failed to evidence a complaint had been documented for patient #8. Review of the client logging notes for patient #8, who received home health aide services only, evidenced on 12-6-2020, "[first name of patient #8] does not want [name of home health aide, employee G] back to his/her house as his/her aide." Review of the client logging notes for patient #8, evidenced on 12-8-2020, "Writer called [first name of patient #8] to discuss why he/she did not want [name of home health aide, employee G]-HHA back. He/she stated that [employee G] was 'too close' with him/her. He/she said that she had written her/him love letters and tried to get him/her to "Move into a house with [employee G] He/she stated that he/she likes [employee G] as an aide but feels as though [employee G] has overstepped [employee G's] boundary. On 1-8-2021 at 11:05 AM, the Director of Clinical Services and the administrator reviewed the above client logging notes and verified patient #8 had expressed dissatisfaction with the behavior of their home health aide, employee G, a HHA from the Columbus branch, which was a complaint, and no complaint was documented for patient #8 in the 2020 complaint log.		branch complaint logs for 2021, and they are 100% compliant with this requirement. The Administrator and Director of Clinical Services will hold a routine standing meeting with the Branch to review 100% of complaints and will review the complaint log weekly for 60 days ensure that all complaints are documented appropriately. After 60 days of 100% compliance, all complaints will be reviewed during the Agency's quarterly QAPI program. The Administrator and Director are responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	

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	410 IAC 17-12-3 (c) (2)			
G 0572 Bldg. 00	484.60(a)(1) Plan of care Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure a registered nurse implemented the physician's order to notify the physician of abnormal findings for 1 (patient #4) of 1 patient with an identified integumentary impairment and failed to ensure services were provided per the plan of care for 2 (patient #4 and 7) of 5 patient records reviewed. The findings included: 1. A review of patient #4's "Home Health Certification and Plan of Care", evidenced a start of care 5/12/20, and contained a plan of care for the certification period 11/8/20-1/6/21, with orders for skilled nursing visits: 5-7 hours per day for 1-2 days per week; 9-11 hours per day for 1-2 days per week; and 3-5 hours per day for 1 day per week. Below said frequency, is another frequency which indicated the patient had chosen to schedule PA hours as follows: 5-7 hours/day x ½ days/week,	G 0572	All Agency nurses have been re-educated on the importance of reporting injuries of unknown origin to the Director of Clinical Services immediately and reporting any abnormal findings to the MD in accordance with physician orders. This re-education included the requirement to document the detailed assessment of any wound within the documentation note. The Agency also contacted all nurses to ensure there are no outstanding unreported injuries of unknown origin, and no further injuries or concerns have been identified. The Director of Clinical Services will complete a focused audit of 100% of nursing notes for the RN mentioned in the survey report	02/12/2021

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	and 9-11 hours/day x 1-2 days/week, and 3-5 hours/day x 1 day per week, and "SN (Skilled Nurse) to perform full, comprehensive assessment every visit and notify physician for any abnormal findings." A review of the visit notes revealed visits and the hours that were provided for certification period 11/8/20 - 1/6/20: 11/12=8h (hours), 11/13=8h, 11/17=8.25h, 11/18=7.75h, 11/19=8h, 11/20=8, 11/24=8h, 11/25=7.75h, 11/26=7.25h, 11/27=6.6h, 12/1=8.25h, 12/2=8h, 12/3=8h, 12/8=8h, 12/9=8h, 12/10=7.75h, 12/11=8h, 12/15=9.75h, 12/17=6.75h, 12/18=9.75h, 12/22=9.75h, 12/23=9.75h, 12/24=7.75h; therefore, the frequency/duration ordered failed to meet the ordered frequency and hours of care ordered on the physician ordered plan of care. A review of the nurse visit notes revealed visits which were neither 5-7 hours of care, 9-11 hours of care, or 3-5 hours of care, as ordered on the plan of care, for the following dates: 11-12, 11-13-20, 11-17, 11-18, 11-19, 11-20, 11-24, 11-25, 11-26, 12-1, 12-2, 12-3, 12-8, 12-9, 12-10, 12-11, 12-17, and 12-24-2020; therefore, the frequency/duration ordered failed to meet the ordered frequency and hours of care ordered on the physician ordered plan of care. A review of a skilled nurse visit note dated 12/2/20 from 8 AM- 4 PM, signed by Employee E, registered nurse, evidenced documentation of "wounds present: see figure." The figure evidenced documentation of a scrape to the right thigh, a bruise to the left knee, and a scratch to the left thigh. The comment section stated, "Pt. (sic patient) tends to put hands between thighs while asleep." The visit note failed to evidence the identified scrape, bruise, and scratch had been		(Employee E) for 30 days to ensure compliance with these requirements. Following 30 days of 100% compliance, the Director of Clinical Services or RN designee will include an audit of all nursing notes during the Agency's 10% quarterly clinical record audit to ensure continued compliance. All Agency employees have received in-service re-education regarding following the Physician ordered Plan of Care as written. Additionally, all internal employees have been re-educated on requirement that schedules match the frequency and duration requested by the patient and approved by the physician. The Administrator has completed a 100% audit of all patient schedules and completed hours, and any discrepancies have been reported to the physician and documented with an order. The Administrator or Director of Clinical Services will audit 100% of completed patient schedules weekly for 5 weeks to ensure all schedules remain compliant with the plan of care. Any discrepancies will continue to be reported to the physician, and an order will be sent for countersignature. After 5 weeks of 100% compliance, the Administrator and Director will include a review of the schedule frequency and duration during the	

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	measured and failed to evidence a descriptions of the areas where the integumentary impairments had been identified. A section titled "Physician Notified" was blank. A review of a skilled nurse visit note dated 12/3/20 from 8 AM - 4 PM, signed by Employee E , registered nurse, evidenced documentation of "wounds present: See figure." The figure evidenced documentation of a scrape to the right thigh, a bruise to the left knee, and a scratch to the left thigh. The comment section stated, "Pt (sic patient) sleeps with hands tucked between legs." The visit note failed to evidence the identified scrape, bruise, and scratch had been measured and failed to evidence a descriptions of the areas where the integumentary impairments had been identified. A section titled "Physician Notified" was blank. A review of a "Client Logging Report, Coordination of Care" dated 12/4/20, evidenced Employee B, the director of clinical services (DOCS,) spoke with the patient's mother and due to the family being out of town, a visit was arranged for 12/7/2020, to assess the identified injuries of unknown origin. A review of a "Client Logging Report, Coordination of Care" dated 12/4/20, evidenced an entry by Employee H "Late entry charting for 12/3/2020: Patient's nurse called in to report 3 new areas of skin impairment. Patient has a new scrape to right thigh, bruise to right knee, and scratch to left thigh above knee." A review of a "Client Logging Report" dated 12/7/20, evidenced an entry by the DOCS which revealed the DOCS went to the home of patient #4 to assess patient #4's injuries of unknown origin.		10% quarterly record review as part of the Agency's QAPI program. The Administrator and Director are responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	

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	The visit notes and the client logging report entries failed to evidence the attending physician had been notified, as ordered on the plan of care, of patient #4's newly identified integumentary impairments of unknown origin. The agency failed to notify the physician of findings at the time discovered/identified, and failed to notify the physician of the assessment findings for injuries of unknown origin after the investigation was complete, 2. The clinical record for patient #7, soc 10/4/2018, was reviewed and contained an agency document titled "Home Health Certification and Plan of Care," for the certification period 11/22/20-1/20/21, which revealed the following: Medicaid PA Program Hours (HHA) [sic home health aide] 5-7 hours/day x 3-5 days/week and 3-5 hours/day x 1 day a week; Medicaid Respite Program Hours (HHA), 1-3 hours/day x 3/5 days/week and 4-6 hours/day x 1 day/week. A review of the visit notes for patient #7 evidenced the following home health aide visits and hours were provided under prior authorization for the certification period 11/22/20-1/20/21, which were not either 5-7 hours or 3-5 hours: 11/24=1h (hour) 8 minutes, 12/1=2h, 12/2=2h, 12/4=6h, 12/4=1h, 12/7=2h, 12/8=2h, and 12/9=2h. 3. On 1-8-2021, at 11:05 AM, the director of nursing services verified the above findings and had nothing further to add. 410 IAC 17-13-1(a)			
G 0584	484.60(b)(3)(4) Verbal orders			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K141	A. BUILDING 00 B. WING	01/11/2021

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

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Bldg. 00	(3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician in accordance with applicable state laws and regulations, as well as the HHA's internal policies. Based on record review and interview, the agency failed to ensure the registered nurse followed agency policy in relation to taking of a telephone order for 1 (Patient #8) of 5 patients whose clinical record was reviewed. The findings included: Review of a policy, "Physician Orders," last review/revised 8-21-2019, evidenced the policy stated, "All medications, treatments and services provided to patients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner ... All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders ... when the nurse or therapist receives a verbal order from the physician, he/she shall write the order as given and then read the order back to	G 0584	The Agency has revised the Agency's Physician Order policy, C-635, to mimic the language in the Conditions of Participation. The revised policy includes instruction on how verbal orders are to be obtained and by whom, as well as the requirement that those verbal orders be documented in writing and sent to the Physician for signature. The Administrator, Director, Branch Manager, and all Clinical Supervisors have been educated on the new policy. The Director of Clinical Services or RN designee will audit 100% of verbal order forms for 30 days to ensure all orders are compliant with Agency policy. After 30 days of 100% compliance, the Director	02/05/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	the physician verifying that the person receiving the order heard it correctly and interpreted the order correctly ... Verbal orders are accepted by authorized, licensed agency personnel in accordance with applicable state law and agency policy ... A system will be used by the agency to ensure the telephone orders are signed and dated by the physician and returned to the patient's clinical record within an appropriate time frame ... Agency will implement a tracking system to assure timely response ... " Review of the clinical record 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 home health aide services and diagnoses to include Parkinson's Disease, diabetes mellitus, and hip pain. Review of the clinical record evidenced a document, "Physician Order for Re-Certification of Services," with date of 12-30-2020, 10:57 AM, written in the field for date/time, evidenced, " Dr [name of Nurse Practitioner] has been notified of the assessment findings from the re-certification visit on date 12-30-2020. The physician, patient/caregiver, and nurse have collaborated in the development and revision of the plan of care. VERBAL ORDER: DISCIPLINE, FREQUENCY AND DURATION Home Health Aide 1 visit/day X 3-5 days/week; 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/her plan of care with confirmation of changes via hospital discharge		or RN designee will review verbal order forms as part of the Agency's 10% quarterly clinical record audit conducted during the Agency's QAPI program. The Administrator and Director of Clinical Services are responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	

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	15K141	A. BUILDING 00 B. WING	01/11/2021

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	paperwork. MEDICATION CHANGES ARE PRESENT- SEE BELOW: Discontinue Amitriptyline 25 mg @ Bedtime; Discontinue Desmopressin 0.2 mg tablet; Begin Amitriptyline 150 MG at bedtime. NEW/CHANGED DIAGNOSIS- SEE BELOW: E 87.1 Hypo-Osmolarity + Hyponatremia. The document was signed by registered nurse (RN), employee H, and dated 12-30-2020, at 10:57 AM. The order failed to evidence it had been read back, as required by agency policy. On 1-7-2021, at 9:52 AM, the director of clinical services (DOCS) indicated the above verbal order was written on 1-7-2021, and had not yet been sent to patient #8's attending provider. The DOCS indicated the agency practice was for the clinician to call the attending provider office to speak with a designated clinician or the provider, to share the findings from the recertification comprehensive assessment, and request authorization to continue services; then the comprehensive assessment was quality reviewed, the plan of care for the new certification period was developed, by or on the 14th day after the comprehensive assessment; the verbal order and the fully developed plan of care, along with the medication profile and reconciliation report, were then faxed to the attending provider. The DOCS, when queried, indicated verbal orders were not reduced to writing by the receiving clinician until the fully developed plan of care had been completed, and was ready to send to the attending provider, up to 14 days after the expiration of the previous certification period. Review of patient #8's client logging notes, evidenced an entry on 12-29-2020, "Call placed to MD office and spoke to [person C.] Reported patient had returned home from his/her			

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	hospitalization for 'not feeling well.' Reported assessment findings from Resumption of Care visit and that no med[ication] changes appeared to be made." Review of patient #8's client logging notes, evidenced an entry on 12-30-2020, at 10:57 AM, "Call placed to MD office and spoke to [person C.] Reported assessment findings from Telemedicine RCT [recertification.] ... Received VO [verbal order] for RCT [recertification.]" Review of a verbal order, dated 12-30-2020, at 10:57 AM, evidenced, " ... During that hospitalization, the below medication changes and below listed diagnosis were made + added to his/her plan of care with confirmation of changes via hospital discharge paperwork ... MEDICATION CHANGES ARE PRESENT-SEE BELOW- Discontinue Amitriptyline 25 MG at bedtime; Discontinue Desmopressin 0.2 MG tablet; Begin Amitriptyline 150 MG at bedtime, NEW CHANGED DIAGNOSIS-SEE BELOW - E 87.1 Hypo-osmolarity + hyponatremia." On 1-7-2020, at 1:32 PM, employee H, RN, stated when queried on what date the verbal order for recertification was obtained, indicated 12-30-2020. When queried if the verbal order was reduced to writing at that time, employee H responded, "No." When asked if the verbal order had been written today [1-7-2021] , employee H replied, "Yes." When asked if the content of the verbal order matched the content of the written order based on the verbal order were identical, employee H replied, "No." On 1-8-2021, at 11:05 AM, the administrator and the director of clinical services, verified the verbal order dated 12-30-2020, failed to evidence it had			

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	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 Bldg. 00	484.60(c)(1) Reviewed, revised by physician every 60 days 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. Based on record review and interview, the agency failed to ensure the attending provider was provided a plan of care for review/revision at least every 60 days, starting with the start of care date, for 1 (patient #8) of 3 patients who were on service at least 60 days, of a sample of 5 patients. The findings included: Review of the clinical record 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. On 11-8-2021, at 11:05 AM, the director of clinical services, indicated the plan of care for the 2nd certification period which began on 1-4-2021, had not been sent to the attending provider for	G 0588	The Administrator, Director of Clinical Services, and all internal clinicians have been re-educated about the requirement that the plan of care be reviewed at least every 60 days beginning with the start of care date, according to federal regulations. The Director of Clinical Services will review 100% of plans of care for a period of 60 days to ensure all plans of care are compliant with this requirement. After 60 days of 100% compliance, the Director or RN designee will continue to include evaluation of the plan of care review dates as part of the Agency's 10% quarterly clinical	02/05/2021

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	15K141	A. BUILDING 00 B. WING	01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	review/revision, and this represented a period of more than 60 days from the start of care date of 11-5-2020. 410 IAC 17-13-1 (a) (2)		record audit during the QAPI program to ensure continued compliance. The Administrator and Director of Clinical Services are responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	
G 0716 Bldg. 00	484.75(b)(6) Preparing clinical notes Preparing clinical notes; Based on record review and interview, the agency failed to ensure the registered nurse, employee C, documented the provision of education/counseling to the parent(s) of an infant related to medication management, as ordered on the medical plan of care, for 1 (patient #10) of 5 patients whose clinical record was reviewed. The findings included: Review of the clinical record for patient #10, evidenced a date of birth of 4-30-2019, with a start of care date of 12-3-2020, and contained a plan of care for the certification period of 12-3-2020 to 1-31-2021, with orders for the skilled nurse (SN) visits which included SN to educate patient/caregiver on the following topics: " ... Medication management ... " Review of the medication listed on the plan of care evidenced: Budesonide Inhalation Suspension, 1 Mg/2 mL, 2 ml / INHALATION, 1 times every 12 hours SOB [shortness of breath]; Captopril 1 mg/1 mL, 5 ml, G-tube, every 8 hours at 6 AM, 2 PM, and 10 PM; Feeding mixture 180 ml, G tube, 4 times every 1 day, 1 pouch of Compleat Blend (10	G 0716	All nurses have been re-educated on the requirement to document the content of any education that is provided during the provision of care, in addition to the topic of education. This item has been added to the Agency's skilled nursing competency form to ensure that all new nurses receive the same education. The Director of Clinical Services will complete a focused audit of 100% of nursing notes for the RN mentioned in the survey report (Employee E) for 30 days to ensure compliance with these requirements. Following 30 days of 100% compliance, the Director of Clinical Services or RN designee will include an audit of all nursing notes during the Agency's 10% quarterly clinical record audit to ensure continued compliance. The Administrator and Director of Clinical Services are responsible	02/05/2021

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	15K141	A. BUILDING 00 B. WING	01/11/2021

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	ounces)- 10 ounces of Pediasure- 4 ounces of water-mix well and divide into 4 feedings of 180 ml each Feedings [gravity]; Furosemide Oral Solution 10 mg/ml-1 ml Oral, once a day; Keppra Oral Solution 10 MG/ML-2 mL, Oral, Once a Day; Tap Water flush - 6 ml - G-tube, every 4 hours (each 3-5 hours) after feedings tube patency; Albuterol Sulfate Inhalation Nebulization Solution- 2.5 MG/3 ML- 0.83%/ 3 mL, INHALATION, PRN [as needed] every 6 hrs SOB [shortness of breath]; Furosemide Oral Solution 10 MG/ML, 0.2 mL, Oral, PRN once a Day DO NOT GIVE UNLESS PARENTS SAY, for congestion; Ibuprofen Oral Suspension 100 MG / 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; Tylenol Infants Oral Suspension 160 MG / 5 ML, 2 ML, ORAL, PRN Every 6 hours pain or fever. Review of the comprehensive assessment dated 12-3-2020, by employee D, a registered nurse, evidenced patient #8 was less than 2 years old with weight of 18 pounds or 8.16 Kilograms. Review of the registered nurse visit note dated 12-8-2020, by employee C, 7:45 AM to 3:45 PM, evidenced in the area "Education Provided" the following: "Education provided (document details of education) report of the day. Medication regimen; Education provided to (specify patient/caregiver/family/oncoming nurse): family; Recipient verbalized 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 immediately, side effects/concerns to report to the agency registered nurse, the maximum dosage of		for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	

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	15K141	A. BUILDING 00 B. WING	01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Tylenol for infants, and/or other possible drug interactions/concerns to report. Review of the registered nurse visit note dated 12-8-2020, by employee C, 3:45 PM to 4:00 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/family/oncoming nurse): family; Recipient verbalized 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 immediately, side effects/concerns to report to the agency registered nurse, the maximum dosage of Tylenol for infants, and/or other possible drug interactions/concerns to report. Review of the registered nurse visit note dated 12-9-2020, by employee C, 7:45 AM to 3:45 PM, evidenced in the area "Education Provided" the following: "Education provided (document details of education) report of the day. Medication Regimen; Education provided to (specify patient/caregiver/family/oncoming nurse): family; Recipient verbalized 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 immediately, side effects/concerns to report to the agency registered nurse, the maximum dosage of Tylenol for infants, and/or other possible drug interactions/concerns to report. Review of the registered nurse visit note dated			

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	15K141	A. BUILDING 00 B. WING	01/11/2021

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	12-9-2020, by employee C, 3:45 PM to 4:00 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/family/oncoming nurse): family; Recipient verbalized 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 immediately, side effects/concerns to report to the agency registered nurse, the maximum dosage of Tylenol for infants, and/or other possible drug interactions/concerns to report. Review of the registered nurse visit note dated 12-10-2020, by employee C, 7:45 AM to 3:45 PM, evidenced in the area "Education Provided" the following: "Education provided (document details of education) report of the day. Medication regimen; Education provided to (specify patient/caregiver/family/oncoming nurse): family; Recipient verbalized 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 immediately, side effects/concerns to report to the agency registered nurse, the maximum dosage of Tylenol for infants, and/or other possible drug interactions/concerns to report. Review of the registered nurse visit note dated 12-10-2020, by employee C, 3:45 PM to 4:15 PM, evidenced in the area "Education Provided" the following: "Education provided (document details of education) report of the day; Education			

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	15K141	A. BUILDING 00 B. WING	01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	provided to (specify patient/caregiver/family/oncoming nurse): family; Recipient verbalized 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 immediately, side effects/concerns to report to the agency registered nurse, the maximum dosage of Tylenol for infants, and/or other possible drug interactions/concerns to report. Review of the registered nurse visit note dated 12-11-2020, by employee C, 8:00 AM to 3:00 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/family/oncoming nurse): family; Recipient verbalized 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 immediately, side effects/concerns to report to the agency registered nurse, the maximum dosage of Tylenol for infants, and/or other possible drug interactions/concerns to report. Review of the registered nurse visit note dated 12-11-2020, by employee 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/family/oncoming nurse): Family; Recipient verbalized understanding of education provided." The visit note failed to document any			

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	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 immediately, side effects/concerns to report to the agency registered nurse, the maximum dosage of Tylenol for infants, and/or other possible drug interactions/concerns to report. Review of the registered nurse visit note dated 12-14-2020, by employee C, 7:45 AM to 3:45 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/family/oncoming nurse): Family; Recipient verbalized 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 immediately, side effects/concerns to report to the agency registered nurse, the maximum dosage of Tylenol for infants, and/or other possible drug interactions/concerns to report. Review of the registered nurse visit note dated 12-14-2020, by employee C, 3:45 PM to 5:00 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/family/oncoming nurse): Family; Recipient verbalized 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			

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TOGETHER HOMECARE	555 E COUNTY LINE ROAD SUITE 105 GREENWOOD, IN 46143

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	immediately, side effects/concerns to report to the agency registered nurse, the maximum dosage of Tylenol for infants, and/or other possible drug interactions/concerns to report. Review of the registered nurse visit note dated 12-15-2020, by employee C, 7:45 AM to 3:45 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/family/oncoming nurse): Family; Recipient verbalized 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 immediately, side effects/concerns to report to the agency registered nurse, the maximum dosage of Tylenol for infants, and/or other possible drug interactions/concerns to report. Review of the registered nurse visit note dated 12-15-2020, by employee C, 3:45 PM to 5:00 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/family/oncoming nurse): Family; Recipient verbalized 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 immediately, side effects/concerns to report to the agency registered nurse, the maximum dosage of Tylenol for infants, and/or other possible drug interactions/concerns to report.			

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	15K141	A. BUILDING 00 B. WING	01/11/2021

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	Review of the website Drugs.com evidenced patient #8 medication of Budesonide had listed side effects for which the doctor may need to be informed immediately: bruising easily, cough, chills, diarrhea, fever, and vomiting. Review of the website Drugs.com evidenced patient #8 medication of Furosemide had an alert for possible anaphylactic allergic reaction, which could occur at any time, and would require emergency medical help for signs and symptoms of hives, difficulty breathing, swelling in the face or throat, red or purple skin rash that spreads and causes blistering and peeling.) Furosemide also required the need to report to the prescribing physician and/or the home health agency nurse, side effects of easy bruising, unusual bleeding, swelling in feet or ankles, diminished urination, and jaundice (yellowing of the skin or eyes.) Review of the Medscape website evidenced Tylenol for infants under the age of 2 years old had a maximum daily dosage for weight of 18 pounds or 8.16 kilograms, of 612 mg of Tylenol per day. On 1-8-2021, at 11:15 AM, the nurse visit notes related to medication management/education for the parent(s) of patient #8 were reviewed with the Director of Clinical Services who confirmed there was inadequate documentation of medication management education for the parent(s) of patient #8, and the clinical notes above failed to evidence which medications were addressed, and the content of any education of the intended effect, the side effects, and interactions of medications, which symptoms to call for emergency and/or agency assistance, or maximum dosages.			

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G 0718 Bldg. 00	410 IAC 17-14-1 (a) (1) (E) 484.75(b)(7) Communication with physicians Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on record review, the agency failed to ensure the registered nurse notified the physician of a patient's integumentary impairment for 1 (patient #4) of 5 patients. Findings include: The clinical record for patient #4, start of care 5/12/20, contained a "Home Health Certification and Plan of Care", for the certification period 11/8/20-1/6/21, which revealed an order stating, "SN (skilled Nurse) to perform full, comprehensive assessment every visit and notify physician for any abnormal findings." A review of a skilled nurse visit note for patient #4, dated 12/2/20 from 8 AM- 4 PM, signed by Employee E documentation of "wounds present: see figure." The figure evidenced a scrape to the right thigh, a bruise to the left knee, and a scratch to the left thigh. The comment section stated, "Pt. (patient #4) tends to put hands between thighs while asleep." The visit noted failed to evidence measurements or descriptions of the areas identified, and the areas titled, "Physician Notified" was blank. A review of a skilled nurse visit note for patient #4, dated 12/3/20 from 8 AM - 4 PM, signed by Employee E, evidenced documentation of "wounds present: See figure." The figure	G 0718	All Agency nurses have been re-educated on the importance of reporting injuries of unknown origin to the Director of Clinical Services and physician immediately. This re-education included the requirements for documenting any wound, including measurement and full description of the wound and peri-wound area. All nurses have acknowledged understanding of this in-service material. The Director of Clinical Services or RN designee will complete a focused audit of 100% of nursing notes for the RN mentioned in the survey report (Employee E) for 30 days to ensure compliance with these requirements. Following 30 days of 100% compliance, the Director of Clinical Services or RN designee will include an audit of nursing notes during the Agency's 10% quarterly clinical record audit to ensure continued compliance. The Administrator and Director of Clinical Services are responsible for monitoring the corrective actions to ensure the deficiency is corrected and will not recur.	02/05/2021

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	evidenced a scrape to the right thigh, a bruise to the left knee, and a scratch to the left thigh. The comment section stated, "Pt sleeps with hands tucked between legs." The visit note failed to evidence measurements or descriptions of the areas included in the assessment. A section titled "Physician Notified" was blank. The registered nurse, employee E, failed to follow the plan of care order to notify the physician of findings at the time they were identified and failed to notify the physician of the assessment findings for injuries of unknown origin after the agency investigation was completed, On 1-8-2021, at 11:05 AM, the director of nursing services verified the above findings and had nothing further to add. 410 IAC 17-14-1 (a) (1) (G)			
G 0802 Bldg. 00	484.80(g)(3) Duties of a HH aide The duties of a home health aide include: (i) The provision of hands-on personal care; (ii) The performance of simple procedures as an extension of therapy or nursing services; (iii) Assistance in ambulation or exercises; and (iv) Assistance in administering medications ordinarily self-administered. Based on record review and interview, the agency failed to ensure home health aide (HHA) assigned care tasks included only the provision of hands on care, the performance of simple procedures as an extension of nursing services, assistance in ambulation or exercises, and assistance with administering medications which were ordinarily	G 0802	All internal staff members have participated in an in-service regarding hands-on personal care tasks on the Medicaid PA care plan, and the requirement to limit all tasks that do not involve hands-on personal care, including housekeeping, to the waiver aide	02/05/2021

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	self-administered, for 1 of 3 (patients #8) patients with home health aide services, out of a sample of 5 patients. The findings included: 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 ... " Review of the HHA care plan, dated 12-30-2020, evidenced the duties for the HHA: "document bowel movement if greater than 3 days- PRN; medication reminder every visit; medication handling (no administration) every visit; assist with ambulation/transfers every visit; use of cane/walker- PRN; prepare/serve meals every visit; Laundry every visit; Dishes, counters, stove, table, every visit; Sweep/Vacuum weekly and PRN; Make bed every visit; Light housekeeping every visit; dust every visit, mop bathroom every visit; mop kitchen weekly and PRN; clean bathroom every visit; change linens		care plan. All PA care plans have been revised with all non-personal care tasks removed. All records are now 100% compliant with this requirement. The Director of Clinical Services will audit 100% of new PA aide care plans for a period of 60 days to ensure they are 100% compliant with the federal requirement at CFR484.80 (g)(3). After 60 days, The Director of Clinical Services or RN designee will include aide care plans in the 10% clinical record audit during the Agency's quarterly QAPI program. The Administrator and Director of Clinical Services are responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	

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	weekly and PRN; Trash removal PRN; for both PA and Waiver services. Waiver services plan of care also evidenced transportation/errands PRN. The HHA prior authorization care plan evidenced duties which were not the provision of hands on care, the performance of simple procedures as an extension of nursing services, assistance in ambulation or exercises, and assistance with administering medications which were ordinarily self-administered, to include sweeping/vacuuming weekly, light housekeeping every visit, dust every visit, and mop bathroom every visit and were not instructed to be provided only if necessary, related, and incidental to the provision of hands-on care Review of HHA visit notes from 11-11-2020 to 1-5-2021, evidenced the HHA had performed tasks other than the provision of hands on care, the performance of simple procedures as an extension of nursing services, assistance in ambulation or exercises, and assistance with administering medications which were ordinarily self-administered (sweeping/vacuuming weekly, light housekeeping every visit, dust every visit, mop bathroom every visit) on 11-11-2020, 11-12, 11-13, 11-16, 11-18, 11-19, 11-20, 11-23, 11-24, 11-25, 11-27, 11-28, 11-30, 12-1, 12-2, 12-3, 12-4, 12-8, 12-9, 12-10, 12-11, 12-14, 12-15, 12-16, 12-17, 12-18, 12-21, 12-22, 12-23-2020, 1-4-2021, and 1-5-2021. On 1-8-2021 at 11:05 AM, the administrator and the director of clinical services indicated believing all the assigned HHA duties for prior authorization services were appropriate, although not all the assigned duties were the provision of hands-on direct patient care or incidental to necessary provision of direct hands on care..			

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G 0942 Bldg. 00	410 IAC 17-14-1 (h) (1-13) 484.105(a) Governing body Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. Based on record review and interview, the governing body failed to ensure it exercised full legal authority and responsibility for the home health agency to include having reviewed and revised a policy, "Physician Orders" to include a defined time limit for the return of physician orders with physician authentication for 1 of 7 policies reviewed. The findings included: Review of a policy, "Physician Orders," last reviewed/revised on 8-21-19, evidenced the policy stated, "All medications, treatments and services provided to patients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner ... " The policy failed to establish an objective timeline for what constituted a "timely manner." On 1-8-2021, at 11:05 AM, the director of clinical services (DOCS) indicated if there had been significant changes at the time of recertification, the expectation was for the verbal order to be written and sent to the attending physician the	G 0942	The Agency, in collaboration with the Governing Body, has revised the Agency's Physician Order policy, C-635, to reflect the language in the Conditions of Participation, and has included the requirement that all Physician orders be signed by the Physician within 30 days of the order date. The Administrator, Director, Branch Manager, and all Clinical Supervisors have been educated on the new policy. The Director of Clinical Services or RN designee will audit 100% of physician orders for 30 days to ensure all orders are compliant with Agency policy - C-635. After 30 days of 100% compliance, the Director or RN designee will review verbal order forms as part of the Agency's 10% quarterly clinical record audit conducted during the Agency's QAPI program. The Administrator and Director of	02/05/2021

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	same or next day. For other orders, the expectation was the orders should be in the clinical record in 14 days. The DOCS verified the policy did not establish the timeframe for return of physician authenticated written and verbal orders. 410 IAC 17-12-1 (b)		Clinical Services are responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	
G 0948 Bldg. 00	484.105(b)(1)(ii) Responsible for all day-to-day operations (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the administrator failed to ensure the registered nurse reported injuries of an unknown origin to the Director of Nursing immediately for 1 (patient #4) of 1 patient with an identified integumentary impairment; failed to ensure patients rights were adhered to by failing to provide services as ordered on the plan of care for 2 (patients #4 and 7) of 5 patients clinical records reviewed; failed to ensure a registered nurse implemented the physician's order to notify the physician of abnormal findings for 1 (patient #4) of 1 patient with an identified integumentary impairment and failed to ensure services were provided per the plan of care for 2 (patient #4 and 7) of 5 patient records reviewed; failed to ensure the registered nurse followed agency policy in relation to taking of a telephone order for 1 (Patient #8) of 5 patients whose clinical record was reviewed; failed to ensure the attending provider was provided a plan of care for review/revision at least every 60 days, starting with the start of care date, for 1 (patient #8) of 3 patients who were on service at least 60 days, of a sample of 5 patients; failed to ensure the registered nurse, employee C, documented the provision of education/counseling to the parent(s) of an infant related to medication	G 0948	The Administrator has participated in and has had direct oversight of all in-services and activities related to the Agency's corrective actions. The Administrator will include validation of the continued corrective actions in the weekly meeting with the Clinical Director. The Administrator will continue to be responsible for the day-to-day operations by overseeing and reporting the Agency's corrective action monitoring results to the Governing Body at the end of the established monitoring periods and quarterly thereafter, as part of the Agency's QAPI program. The Administrator is responsible for monitoring the corrective actions to ensure the deficiency does not recur.	02/05/2021

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	15K141	A. BUILDING 00 B. WING	01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	management, as ordered on the medical plan of care, for 1 (patient #10) of 5 patients whose clinical record was reviewed; failed to ensure home health aide (HHA) assigned care tasks included only the provision of hands on care, the performance of simple procedures as an extension of nursing services, assistance in ambulation or exercises, and assistance with administering medications which were ordinarily self-administered, for 2 of 3 patients with home health aide services, out of a sample of 5 patients, for 1 of 1 home health agency administrator. The findings included: The administrator failed to ensure the registered nurse reported injuries of an unknown origin to the Director of Clinical Services immediately. (See G 430) The administrator failed to ensure patients rights were adhered to by failing to provide services as ordered on the plan of care. (See G 436) The administrator failed to to ensure a complaint was recognized and documented with resolution. (See G 484) The administrator failed to ensure a registered nurse implemented the physician's order to notify the physician of abnormal findings and failed to ensure services were provided per the plan of care. (See G 572) The administrator failed to ensure the registered nurse followed agency policy in relation to taking of a telephone order. (See G 584) The administrator failed to ensure the attending provider was provided a plan of care for			

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	review/revision at least every 60 days, starting with the start of care date. (See G 588) The administrator failed to ensure the registered nurse, employee C, documented the provision of education/counseling to the parent(s) of an infant related to medication management, as ordered on the medical plan of care. (See G 716) The administrator failed to ensure home health aide (HHA) assigned care tasks included only the provision of hands on care, the performance of simple procedures as an extension of nursing services, assistance in ambulation or exercises, and assistance with administering medications which were ordinarily self-administered. (See G 802) 410 IAC 17-12-1 (c) (1)			
G 0964 Bldg. 00	484.105(c)(3) Coordinate referrals; Coordinating referrals, Based on record review and interview, the director of clinical services failed to ensure a referral was initiated and coordinated for an evaluation for the appropriateness of physical therapy services for 1 (patient #8) of 1 patient with multiple falls, hip pain, shoulder arthritis, and diagnosis of Parkinson's disease, out of a total sample of 5 patients. The findings included: Review of the job description for Director of Clinical Services (DOCS), signed by the DOCS on 8-21-2019, evidenced under "Essential functions/Areas of Accountability" the DOCS " 1. Plans, directs, coordinates and monitors the	G 0964	The Administrator, Director of Clinical Services, and all internal clinicians have been educated on the requirement to continually assess the changing needs of patients, including the need for any therapy services, and to seek referrals from the Physician when the assessing nurse determines that a therapy consult may be needed. This education also included a new process to specifically target patients with multiple falls. A section has been added to all Agency assessment forms to remind the assessing nurse that any clinical indication	02/12/2021

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	15K141	A. BUILDING 00 B. WING	01/11/2021

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	delivery of all direct and indirect services to Agency home care clients ... Identifies systems to recognize client needs, respond to client needs, respond to client needs, and to measure the outcome of Agency interventions ... " Review of the clinical record 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 to 1-3-2021, with orders for home health aide services, and diagnoses to include Parkinson's Disease, Diabetes Mellitus, and hip pain. The plan of care evidenced patient #8 had a fall approximately 2 weeks prior to admission, and had a cane and rollator which did not reduce falls. Review of the client logging dated 11-16-2020, evidenced, " ... new caregiver out at [name of patient 8,] informed us that [name of patient 8] had numerous falls yesterday. Paramedics were not called but he/she was able to get seen by a doctor this morning." Review of the clinical record evidenced an X-ray report dated 11-17-2020, "INDICATION: pain in right shoulder ... IMPRESSION: Arthritic changes DISCUSSION: There is AC [acromial-clavicular] joint DJD [degenerative disc disease] with bony hypertrophy and soft tissue fullness ... " On 1-6-2021 at 3:50 PM, when queried if a physical therapy evaluation had been considered and a referral coordinated for patient #8, indicated there was no evidence in the clinical record the registered nurse (RN) case manager, employee H, had pursued this for patient #8 after multiple recent falls and with diagnosis of Parkinson's Disease. On 1-7-2021, at 1:32 PM, during a telephone		for therapy, whether speech, occupational, physical, or otherwise, must be reported to the Physician, and therapy referral / consult must be requested. Additionally, all patient falls will be entered into a new tracker overseen by the Director, and any patient with a fall frequency that exceeds the Agency's threshold will be contacted by the Director or RN designee to discuss a referral to Physical Therapy. The supervising Physician will be notified of the fall prevalence, and a therapy consult will be requested. The Administrator and Director of Clinical Services will audit the agency's fall log and new fall tracker for 100% of falls for the next 60 days to ensure compliance with this new process. The Director or RN designee will audit 100% of completed assessments for 60 days to ensure any assessment findings that indicate a need for any type of therapy, along with subsequent request to MD for therapy referral, is documented in the clinical record. After 60 days, the Director will continue to monitor the fall log and tracker weekly to ensure continued compliance, and the comprehensive assessments will continue to be monitored as part of the Agency's 10% quarterly record review. The continued	

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	interview with RN, employee H, when queried if had considered coordinating with the DOCS for a referral for a physical therapy evaluation for patient #8, replied, "No." On 1-8-2021, at 11:05 AM, the director of clinical services and the administrator indicated having access to therapists for patient evaluations, and for treatment when appropriate. During telephone interview on 1-11-2021, at 3:21 PM, person B, Certified Medical Assistant for person D, Nurse Practitioner for patient #8, indicated after having spoken to person D, patient #8, based on diagnosis of Parkinson's disease and 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)		compliance for the assessments and fall log / fall tracker will audited and resulted in the Agency's quarterly QAPI program report. The Administrator and Director of Clinical Services are responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	
G 0966 Bldg. 00	484.105(c)(4) Assure patient needs are continually assessed Assuring that patient needs are continually assessed, and Based on record review and interview, the director of clinical services failed to ensure a patient's needs were continually assessed in relation to a patient with multiple falls, diagnoses to include Parkinson's disease, hip pain, shoulder arthritis, and recent acute care hospitalization, for the need	G 0966	The Administrator, Director of Clinical Services, and all internal clinicians have been educated on the importance of continually assessing the changing needs of patients, including the need for physical, occupational, speech, or	02/12/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15K141	A. BUILDING 00 B. WING	01/11/2021

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

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	to consider a physical therapy evaluation for 1 (patient #8) of 1 patient with multiple falls, hip pain, shoulder arthritis, and use of assistive devices which did not prevent falls, out of a total sample of 5 patients. The findings included: Review of the job description for Director of Clinical Services (DOCS), signed by the DOCS on 8-21-2019, evidenced under "Essential functions/Areas of Accountability" the DOCS " 1. Plans, directs, coordinates and monitors the delivery of all direct and indirect services to Agency home care clients ... Identifies systems to recognize client needs, respond to client needs, respond to client needs, and to measure the outcome of Agency interventions ... " Review of the clinical record 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 to 1-3-2021, with orders for home health aide services, and diagnoses to include Parkinson's disease, Diabetes Mellitus, and hip pain. The plan of care evidenced patient #8 had a fall approximately 2 weeks prior to admission, and had a cane and rollator which did not reduce falls. Review of the client logging dated 11-16-2020, evidenced, " ... new caregiver out at [name of patient 8,] informed us that [name of patient 8] had numerous falls yesterday. Paramedics were not called but he/she was able to get seen by a doctor this morning." Review of the clinical record evidenced an X-ray report dated 11-17-2020, "INDICATION: pain in right shoulder ... IMPRESSION: Arthritic changes DISCUSSION: There is AC [acromial-clavicular]		other therapy services, and the requirement to seek therapy referrals or consults from the Physician when the assessing nurse determines that therapy may be indicated. The Director or RN designee will complete a focused audit of 100% of completed comprehensive assessments for 60 days to ensure any assessment findings that indicate a need for any type of therapy, along with subsequent request to MD for therapy referral, are documented in the clinical record. Following the 60-day monitoring period, all comprehensive assessments will continue to be monitored as part of the Agency's 10% quarterly record review to ensure continued compliance. The Administrator and Director of Clinical Services are responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	

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	joint DJD [degenerative disc disease] with bony hypertrophy and soft tissue fullness ... " Review of a comprehensive assessment for resumption of care, dated 12-28-2020, and a comprehensive assessment dated 12-30-2020, evidenced patient #8 had gone to the emergency room of an acute care hospital, and was kept overnight. Review of a hospital discharge summary, dated 12-24-2020, evidenced admission date of 12-23-2020, for intravenous therapy for hyponatremia (low blood sodium) and discharged on 12-24-2020. On 1-6-2021 at 3:50 PM, when queried if a physical therapy evaluation had been considered after recent reported falls and patient #8's diagnoses, the director of clinical services indicated there was no documentation in the clinical record the registered nurse (RN) case manager, employee H, had pursued any referrals for patient #8. On 1-7-2021, at 1:32 PM, during a telephone interview with RN, employee H, when queried if had considered coordinating with the DOCS for a referral for a physical therapy evaluation for patient #8, replied, "No." On 1-8-2021, at 11:05 AM, the director of clinical services and the administrator indicated having access to therapists for patient evaluations, and for treatment plans when appropriate. During telephone interview on 1-11-2021, at 3:21 PM, person B, Certified Medical Assistant for person D, Nurse Practitioner for patient #8, indicated after having spoken to person D, patient #8, based on diagnosis of Parkinson's disease and			

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	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)			