STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOGETHER HOMECARE	5614 INDUSTRIAL ROAD, FORT WAYNE, IN, 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	Initial Comments This visit was for a State Relicensure and complaint survey. Survey Dates: 5/17, 5/18, 5/19, 5/20, and 5/23/2022. Census: 125 Complaint #29494: Unsubstantiated, due to lack of sufficient evidence. Complaint #29806 - Unsubstantiated, due to lack of sufficient evidence. Complaint #29807 - Unsubstantiated, due to lack of sufficient evidence. These deficiencies reflect State Findings cited in accordance with 410 IAC 17.	N0000	N 0000: Together Homecare(“Together”) submits the following Plan of Correction as required by State andFederal law. Together’s submission of this Plan of Correction should notbe taken as an agreement with or admission of any of the findings contained therein.Together hereby expressly reserves the right to challenge the factual findings,legal conclusions, and allegations contained in the underlying reports. Compliance has beenand will be achieved no later than the last completion date identified in thePlan of Correction. Together desires this Plan of Correction to beconsidered our Creditable Allegation of Compliance.	2022-06-22
G0000	This visit was for a Federal Recertification and State	G0000	G 0000:	2022-06-22

	Relicensure survey of Together Homecare with 3 complaints. Survey Dates: 5/17, 5/18, 5/19, 5/20, and 5/23/2022. Census: 125 Complaint #29494: Unsubstantiated, due to lack of sufficient evidence. Complaint #29806 - Unsubstantiated, due to lack of sufficient evidence. Complaint #29807 - Unsubstantiated, due to lack of sufficient evidence. These deficiencies reflect State Findings cited in accordance with 410 IAC 17.		Together Homecare("Together") submits the following Plan of Correction as required by State andFederal law. Together's submission of this Plan of Correction should notbe taken as an agreement with or admission of any of the findings contained therein.Together hereby expressly reserves the right to challenge the factual findings,legal conclusions, and allegations contained in the underlying reports. Compliance has beenand will be achieved no later than the last completion date identified in thePlan of Correction. Together desires this Plan of Correction to beconsidered our Creditable Allegation of Compliance.	
E0000	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: 5/17, 5/18, 5/19, 5/20, and 5/23/2022. Census: 125 At this Emergency Preparedness survey, Together Homecare was	E0000		2022-06-22

	Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.			
N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or	N0464	N 464 In acknowledgement of the IDOH memo, waiving the state TBrequirements when a national standard is adopted, the Governing Body approvedan updated Health Screening policy in January 2020, in accordance with theCenters for Disease Control national standards for TB testing for healthcareworkers. The Agency's policy Occupational Exposure to Tuberculosis D257 hasbeen updated to align with CDC national standards. A new Governing Body meetingwas held to approve this policy modification and to formally acknowledge theformal adoption of the CDC national standard in 2021, which was reflected inthe Health Screening policy. All staff members have participated in anin-service regarding the Agency's TB policy and CDC national standards. Allemployee files are 100% compliant with Agency policies and the CDC nationalstandard, as allowed by the IDOH waiver. All incoming staff members responsible for onboarding newemployees will continue to	2022-06-22

	(B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. 1. A review of the Indiana Administrative Code 410 IAC 17-12-1(i)-4- revealed, &(4) After baseline testing, tuberculosis screening must: (A) be completed annually &. " 2. A review of the personnel record of Employee RN #1 (registered nurse) revealed the date of the most recent tuberculosis (TB) test or screen was 12/14/20. 3. A review of the personnel record of Employee HHA #2 revealed the date of the most recent TB test or screen was 02/7/2020. 4. During interview on 5/20/22 at 1:00 p.m., Administrative Staff #2 indicated the agency did not have documentary evidence of an annual TB risk assessment, at minimum, for RN #1 and HHA #2.		be educated on the Agency's policies regarding TBscreening and testing. The Governing Body will continue to review policies forany state or federal changes, and at least annually, to ensure all Agencypolicies continue to align with state and federal regulations. The Administrator or designee will audit 100% of personnelfiles for 30 days to ensure continued compliance with Agency policies for TBtesting and screening. After 30 days, the Agency will include a review of TBtesting and screening during the 10% quarterly personnel file audit, as part ofthe Agency's QAPI program to ensure continued compliance. The Administrator and Director of Clinical Services areresponsible for monitoring these corrective actions to ensure the deficiency iscorrected and will not recur. Completed 6/22/22 and ongoing.	
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as	G0544	G 544 All Registered Nurses responsible for updating thecomprehensive assessment have been educated that one RN should complete	2022-06-22

	decline or improvement in the patient's health status, but not less frequently than- Clinical record review for Patient #7, with start of care date of 01/07/2022, included an agency document titled Form Type: Recertification-OASIS D1 , dated 03/04/2022 and 05/04/2022. The recertification assessments each failed to include vital signs and noted that the visits were conducted via telemedicine, with an unknown staffer in the home conveying the information to the RN (assessment over the phone). During an interview on 5/20/2022 at 2:10PM, the director of nursing indicated when a nurse is in the home, caring for a patient, that nurse will provide patient information to the registered nurse, over the phone, who then completes the comprehensive re-assessment.		anddocument the assessment. Furthermore, all Registered Nurses responsible forupdating the comprehensive assessment have been educated that telemedicinevisits are not permitted after June 30, 2022, in accordance with state andfederal guidelines. All incoming RNs responsible for updating the comprehensiveassessment will receive this education during the orientation and training period.The Director of Clinical Services or designated RN will review 100% ofcompleted comprehensive assessments for 30 days to ensure compliance with thisrequirement is maintained. After 30 days of compliance, the Director ofClinical Services or designated RN will review comprehensive assessments duringthe quarterly 10% clinical record audit, as part of the Agency's QAPI program. The Administrator and Director of Clinical Services areresponsible for monitoring these corrective actions to ensure the deficiency iscorrected and will not recur. Completed 6/22/22 and ongoing.	
G0600	Coordination of Care 484.60(d)	G0600	G 600	2022-06-22

	Standard: Coordination of care. The HHA must: 1. Clinical record review for Patient #1 evidenced a Plan of Care for certification period 3/20/2022 5/18/2022, with an order for & Ferrous sulfate [to improve the iron level] & on hold until labs are drawn reported per SN [skilled nurse] 10/1/2021 &. 2. During an interview at the exit conference on 5/23/2022 at 3:53 PM, the Director of Clinical Services confirmed the agency did not know if the lab tests were completed or if the medication was current or on hold. He / She further confirmed that coordination of care was not completed.		All nurses responsible for case management have beenre-educated on the requirement to coordinate care with other service providersat all necessary timepoints, as well as the requirement to ensure allmedications and treatments are accurate based on information resulting fromcare coordination. The medication profile for patient #1 has been updated toaccurately reflect the current medication regimen, and the coordination of carehas been documented in the “Client Loggings” portion of the clinical record. All incoming nurses responsible for case management willreceive this education during the orientation and training period. The Directorof Clinical Services or designated RN will audit 100% of medication profilesand Client Loggings for 30 days to ensure continued compliance with theserequirements. After 30 days of compliance, the Director of Clinical Services ordesignated RN will include a review of the medication profile and ClientLoggings during the quarterly 10% clinical record audit, as part of theAgency’s QAPI program, to ensure continued compliance. The Administrator and Director of Clinical Services	

			these corrective actions to ensure the deficiency iscorrected and will not recur. Completed 6/22/22 and ongoing.	
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Clinical record review for Patient #2, with start of care date of 02/15/2022, included a Plan of Care for the certification period of 4/16/22 to 6/14/22 with orders for aide services to assist with bathing at a sink with each visit. The plan of care identified Patient 2s functional limitations included ambulation and endurance, utilized a wheel chair for mobility, utilized a Hoyer [mechanical lift to assist to transfer a patient from surface to surface] transfer for transfers from their hospital bed to other surfaces, and Patient # 2 was on continuous oxygen at 3 liters / minute per nasal canula. The Aide Care Plan, dated 02/15/2022, included the home health aide task of a sink bath, with every aide care visit. A review of eleven home health aide visit care notes, dated from 5/02/2022 through 5/18/2022, each	G0798	G 798 All direct-care employees have been re-educated on therequirement to perform tasks according to the written care plan, and to reportany inconsistencies between the patient's requested care and the written careplan to the Agency immediately. All registered nurses responsible fordeveloping and maintaining the aide care plan have been re-educated on therequirement to ensure the care plan and POC have matching tasks that arepatient-specific. The care plan for patient #2 is compliant with thisrequirement, and the revised plan of care has been sent to the provider forcountersignature. All employees will continue to receive this education duringthe orientation and training process. The Director of Clinical Services ordesignated RN will audit 100% of aide care plans for 30 days to ensure tasksare accurately documented. After 30 days, aide care plans will be included inthe 10% quarterly clinical record audit, as part of	2022-06-22

	evidenced aide documentation that they assisted Patient #2 with bed baths, during each of the eleven aide care visits reviewed. During an interview on 5/18/2022 at 4:00PM, the director of clinical services indicated the home health aide is to follow the aide care plan and a sink bath takes place with patient sitting in front of a sink.		the Agency's QAPI programto ensure continued compliance. The Administrator and Director of Clinical Services areresponsible for monitoring these corrective actions to ensure the deficiency iscorrected and will not recur. Completed 6/22/22 and ongoing.	
G0952	Ensure that HHA employs qualified personnel 484.105(b)(1)(iv) (iv) Ensure that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies. 1. During a home visit observation on 5/18/2022, Registered Nurse (RN) #1, performed suctioning of Patient #1 s tracheostomy tube (a tube inserted into the windpipe to assist with breathing). When queried about the tracheostomy care he / she provided for Patient #1, RN #1 relayed he / she completed suctioning and that the tracheostomy tube was changed on his / her scheduled day off and that the daily tracheostomy care was provided by the patient's primary care giver. RN #1 indicated he / she was the primary nurse for Patient #1 and provided skilled nurse care 4 days a week, 8 hour shifts. 2. A chart review was completed for Patient #1 on 5/18/2022, included physician orders & inner cannula [a tube that acts as a liner to the main tracheostomy tube]	G0952	G 0952 The Director of Clinical Services re-verified competency intracheostomy care for RN #1 identified in the survey report. Documentation ofthis competency verification has been added to the employee's personnel file,and the parent of the patient to whom RN #1 provides care has verbalizedsatisfaction with the RN #1's ability to competently perform tracheostomy care.The competency evaluations for all Agency nurses have been reviewed to ensurethat competency for all tasks is properly documented. All personnel records are100% compliant. The Administrator will review 100% of new employee files fora period of 30 days to ensure competency forms are complete and accurate. After30 days of compliance, the Administrator	2022-06-22

	care daily and PRN (as needed) & change trach [tracheostomy] ties [ties hold the phalange in place; the phalange holds the tracheostomy tube in place] & every other day &. 3. Review of the agency complaint log revealed documentation of a complaint, dated 4/7/2022 regarding Patient #1. The complaint indicated Patient #1 s primary caregiver called the agency at 2:48 PM and spoke with the Director of Clinical Services and relayed that they believed & [RN #1] does not know how to change [Patient #1 s] trach &. 4. Review of the personnel record for RN #1 revealed a Skilled Competency Form dated 12/23/2020. The skill section included care of a tracheostomy, which was blank. 5. A review of an undated agency policy titled Performance Evaluation D-260 identified the purpose, among others, & to determine need for further training &.		or designee will include a review ofcompetency evaluations during the 10% quarterly personnel file audit, as partof the Agency's QAPI program, to ensure continued compliance. The Administrator and Director of Clinical Services areresponsible for monitoring these corrective actions to ensure the deficiency iscorrected and will not recur. Completed 6/22/22 and ongoing.	

	6. Review of an agency job description for a registered nurse revealed Essential Functions/ Areas of Accountability of & Consistently demonstrates competency with technical nursing skills & and Demonstrates competency in areas of assignment or identifies the need for additional training &. 7. During an interview on 5/19/2022 at 3:15 PM, the Administrator confirmed RN #1 was not checked for competency in managing a tracheostomy.			
G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. 1. A home visit observation was scheduled for 5/18/2022 at 10:30 AM at the residence of Patient # 1, to observe a registered nurse [RN] complete a recertification assessment. Upon arrival to the visit at 10:25 AM, the Director of Clinical Services stated, The assessment was completed earlier today. Registered Nurse (RN) #1 was present in the home, to provide patient care, and did not complete the recertification reassessment during the home visit observation. RN #2 was not present in the home during the home visit observation.	G1024	G 1024 The clinical record for patient #1 has been modified tocorrectly identify the visit time for the assessment on 5/18/2022. All nurseshave been re-educated on the importance of modifying the visit time on eachassessment form to accurately reflect the start and stop time of the visit. All incoming nurses will continue to be educated on visittimes as part of the documentation training process during orientation. TheDirector of Clinical Services or designee will audit 100% of patientassessments for 30 days to ensure continued compliance with documenting visittimes. After 30 days, the Director of Clinical Services or designated	2022-06-22

	2. Review of Patient #1's recertification assessment revealed the assessment was completed on 5/18/2022, by RN #2; the document was dated and time of visit as 5-18-2022 / 10:00 11:00. 3. During an interview on 5/20/2022 at 3:06 PM, both the Administrator and the Director of Clinical Services confirmed documentation of the home visit and patient assessment should include the actual time of the visit. 4. Review of an undated agency policy titled Clinical Documentation C-680 stated documentation for each visit should include & Actual time and length of the patient visit &. 410 IAC 17 - 15 - 1(a)(7)		RN willinclude a review of patient assessments during the 10% quarterly clinicalrecord audit, as part of the Agency's QAPI program to ensure continuedcompliance. The Administrator and Director of Clinical Services areresponsible for monitoring these corrective actions to ensure the deficiency iscorrected and will not recur. Completed 6/22/22 and ongoing.	

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

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