STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K128	A. BUILDING B. WING	**10/24/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOGETHER HOMECARE	**8606 ALLISONVILLE ROAD STE 300 , INDIANAPOLIS, Indiana, 46250**

(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
G0000	INITIAL COMMENTS This visit was for a Federal and State complaint survey of a Home Health Agency Agency. This complaint was previously submitted on 08-16-2018, as complaint #IN00271174, as a Personal Services Agency (PSA), and was initially investigated on 08-17-22. The complaint was determined not to have occurred at the PSA agency. The complaint investigation was abandoned and on 09-02-22, it was transferred/submitted to the Home and Community-Based Care division for investigation. Survey Dates: 10-20, 10-21, and 10-24-2022 Complaint: #71732 Unsubstantiated. No federal or state deficiencies were cited. Census: 208 Together Homecare was found to have been in compliance with the requirements of 42 CFR 484 et seq. and 410 IAC 17 et seq. for a home health agency. QR by Area 3 on 10-26-2022	G0000		

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