STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K128	A. BUILDING 00 B. WING	06/14/2021

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

(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 Federal Recertification and State Re-Licensure Survey of a Medicaid Home Health provider in conjunction with 2 complaints. Complaint #: IN 00319604 Unsubstantiated Complaint #: IN 00343773 Unsubstantiated. Survey Date: 6/4/2021, 6/7/21, 6/8/21, 6/9/21, 6/10/21 and 6/14/21 Facility #: 013608 Provider #: 15K128 Medicaid #: 201279300 Quality Review completed on 6/24/2021 by Area 3	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.	
G 0528 Bldg. 00	484.55(c)(1) Health, psychosocial, functional, cognition The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to ensure all patients received an age-appropriate comprehensive assessment that accurately reflected the patient's health, psychosocial, functional, and cognitive status in 2 of 4 active records reviewed. (Patients #1, 3) Findings include:	G 0528	The Agency has created a pediatric assessment form for patients 17 and under, adapted from the Briggs Comprehensive Pediatric Assessment form. All nurses responsible for completing the comprehensive assessment have been in-serviced on the new assessment form, as well as the	07/02/2021

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

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	1. The clinical record for patient #1 was reviewed and contained a plan of care for the certification period (make sure when you are referring to the plan of care that you are using all the language in red, this is a standard practice taught by CMS) of 5/11/21 - 7/9/21, which revealed patient #1 had with a primary diagnosis of Bronchopulmonary Dysplasia (A form of chronic lung disease that affectss newborns, most often those who are born prematurely, where the lungs and the airways [bronchi] are damaged, causing tissue destruction [dyplasia] in the tiny aidr sacs of the lung [alveoli]) need to describe all diagnoses and secondary diagnoses of postsurgical malabsorption (a condition or defect that occurs during the digestion and absorption of food nutrients by the gastrointestinal [GI] tract following GI surgical procedures), chronic respiratory disease (progressive destruction of the air sacs in the lungs and loss of repiratory membrane for oxygen exchange) ...; do not use the dots unless it is a quote chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide); white matter disease (A disease that affects the nerves that link various parts of the brain to each other and to the spinal cord); diarrhea; nutritional deficiency (Occurs when the body doesn't absorb or get from food the necessary amount of nutrients); delayed milestone in childhood (A condition where a child does not reach one of the states at the expected age); incisional hernia with obstruction (Happens when a weakness in the muscle of the abdomen to protrude through the muscle of the abdomen allows the tiessues of the abdomen to protrude through the muscle, appears as a bulge under the skin and can be painful or tender to the touch. Complications are bowel obstruction and strangulation with can cause tissue death in the intestine) ...; gastrostomy		requirement to accurately document the patient's health, psychosocial, functional, and cognitive status within the assessment form. All comprehensive assessments for patients 17 years of age and under will be completed using this new form, effective immediately. All future nurses responsible for completing comprehensive assessments will be oriented to the pediatric assessment form upon hire. The Director of Clinical Services will audit 100% of pediatric patient assessments for a period of 30 days to ensure 100% compliance with the new form. After 30 days, the Director of Clinical Services will incorporate pediatric patient assessments in the Agency's quarterly 10% clinical record audit, as part of the Agency's QAPI Program to ensure continued compliance. The Director of Clinical Services is responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur. The Administrator and Director of Clinical Services are responsible for monitoring the corrective actions to ensure the deficiency is corrected and will not recur. Completed 7/02/2021 and	

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	(G-tube) status (tube inserted surgically into the stomach so liquid nutrition and fluids can be provided); dehydration; hyperosmolality (loss of water makes the blood more concentrated than normal such as high sodium, gloucose and other substances) and hypernatremia (high levels of sodium in the blood-not enough water); and tracheostomy (trach) status (opening created at the front of the neck so a trbe can be inserted into the windpipe [trachea] to help you breathe). Review of a comprehensive assessment titled "ROC/ RCT (Resumption of care/ Recertification) Assessment - Non-OASIS", dated 5/6/21 at 5 PM - 5:30 PM. The Non-Oasis assessment document are used for adults, 18 years and older. The assessment revealed the patient was a mobile, 2 year old toddler The patient's risk for hospitalization included polypharmacy only. Patient #1 lived with parents and sister on the ground floor of a 2 story house with steps, which were gated, and the patient was active, ambulatory without devices other than bilateral AFOs (Ankle Foot Orthosis). Patient #1 was fully dependent for all needs and was unable to speak due to the presence of a tracheostomy. (trach) Heart rate, respirations, and temperature were "WNL (Within Normal Limits." The Braden Scale evidenced "little risk." Patient #1 experienced oral aversion and was fed via G-tube (gastrostomy tube) but could have pleasure foods. The patient was receiving speech, physical, and occupational therapy, and the fall risk assessment evidenced that a continued fall prevention program was in place. Patient #1 had moderate strength in all extremities, a steady gait, and used a stroller for distances. The patient had impaired speech and developmental delay, and emotional/behavioral status was "WNL". The assessment identified no suicide risk. The patient had granulation tissue		ongoing.	

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	removed from the trachea on 5/5/21 and the trach stoma was "WNL". The assessment failed to be specific for pediatric patients and failed to evidence any diagnoses, including diagnoses related to the reason for home health care. (see plan of care entry below) The hospital risk assessment failed to include significant risk factors including the patient's fragile respiratory status resulting from the trach and bronchopulmonary dysplasia (BPD) diagnosis, potential for failure to thrive and poor nutritional status related to malabsorption and diarrhea, dehydration related to diarrhea, high risk of emergencies related to decannulation (accidental dislodgement of the trach) and dislodgement of the G-tube, and emergencies and/or illness of a toddler aged child. The assessment failed to address fall prevention specific to a 2 year old (i.e. gates, lack of proprioception, developmental safeguards, use of car seat), failed to identify a specific fall prevention program being used and what education was provided. The assessment failed to use an appropriate pressure sore assessment (as the Braden scale is used in the adult population vs the Braden Q for pediatric patients). Physical assessment failed to evidence that a blood pressure was obtained with standard vital signs, included a head circumference, and included review of the male genitals, including presence of descended testes and absence of inguinal hernia, both standard in pediatric assessments. The assessment failed to define or identify specific pleasure foods, including how they should be prepared, offered, and encouraged. (i.e. finger food, pureed, small bites). The neurological assessment evidenced impaired speech and developmental delay but failed to evidence how the patient communicated, why and when the			

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	patient wore AFOs, and exercises/tools recommended by therapy to address speech, development, and motor skills. Review of patient #1's emotional/ behavioral status evidenced WNL, but failed to identify what was normal for a 2 year old the existing diagnoses. The patient was not at risk for suicide risk, and assessment not appropriate for a 2 year old. The assessment failed to assess standard behavior and emotional development and response of a 2 year old, and failed to include address the patient's ability to self soothe, sleep patterns, ability to socialize, or the quality of his behavior, including discipline, anxiety, separation from parents, and fears related to hospitalization and medical treatment. The assessment failed to evidence the quality of the trach and G-tube stomas (pink, healed, granulating, drainage, etc.) and failed to include complete and accurate assessment for patient #1's overall health, psychosocial, functional, and cognitive status. 2. During a home visit on 6/8/21 from 9 AM - 11 AM, patient #3 was observed seated in the floor watching television. The patient's grandmother was present and was interviewed concerning diagnoses and care. The grandmother stated the patient was diagnosed with autism prior to the age of 3 years, and could play instruments, was verbal, and had a "photographic" memory. The patient's biological mother cohabitated with a man not related to the patient, who threw him against the wall and "dented" his skull when the patient was 3 years old. The patient is currently profoundly delayed, has left sided hemiparesis, is non-verbal, and is dependent for all care. All needs must be anticipated and patient #3 must be supervised at all times due to delays and seizures. The grandmother stated patient #3 vomits when anxious and with certain foods and once it starts			

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	it will go on all day. The patient can feed himself finger foods but must be watched constantly to avoid stuffing his mouth and/or choking. She stated the patient experiences atopic dermatitis "all over his body" but did not discuss treatment. The surveyor observed gates between the kitchen and living room area (where the patient spends most of the time) and the bedrooms and living room area. The grandmother stated the patient is non-ambulatory but was able to pull himself up to stationary objects, placing him at risk for falling and fractures due to significant osteoporosis caused from lack of use of the limbs. She stated the patient was no longer safe in the stander due to risk of fractures, therefore it was not used. The hoyer was also not used due to the patient's fear, however she stated the patient had become almost too heavy to lift and she was concerned about the nurses trying to transfer him. The clinical record for patient #3 was reviewed and contained a plan of care for the certification period 5/4/21 - 7/2/21 evidenced a primary diagnosis of post traumatic seizures (long-recognized complication of traumatic brain injury) and secondary diagnoses of autistic disorder (serious developmental disorder that impairs the ability to communicate and interact), quadriplegia (paralysis of all four limbs), tic disorder (compulsive, repetitive sound or movement that's often difficult to control), feeding difficulties (broad term used to describe a variety of feeding or mealtime behaviors perceived as problematic for a child or family), gastro-esophageal reflux (digestive disease in which stomach acid or bile irritates the food pipe lining), atopic dermatitis (itchy inflammation of the skin), laryngeal spasm (vocal cords suddenly seize or close when taking a breath, blocking airflow into the lungs, often happens at night,with			

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	people waking up from a sound sleep unable to speak or breathe), other osteoporosis (bones are weaker than normal but not so far gone that they break easily), nausea with vomiting. Review of the comprehensive assessment titled "ROC/ RCT Comprehensive Assessment - Non-OASIS", dated 4/29/21 from 9:10 AM - 10:00 AM. The Non-Oasis assessment document are used for adults, 18 years and older. The assessment revealed the patient was a 13 year old pediatric patient who lived with his grandmother, who was his legal guardian, and her significant other in a single family home with 4 dogs and 4 cats. The patient's grandmother worked full time. The patient's hospital risk included polypharmacy only. A fall risk assessment evidenced visual impairment, 3 or more co-existing diagnoses, environmental hazards, incontinence, and cognitive impairment. The assessment revealed a fall precautions plan continued, and fall education was provided. Review of living arrangements evidenced "NA, no environmental barriers/hazards." A FLACC pain assessment evidenced a score of zero, or no pain. Physical assessment evidenced a heart rate of 44 beats/minute with a history of chronic bradycardia. The patient scored at moderate risk for pressure sores based on use of the Braden Scale. The intervention guide for moderate risk included frequent turning with a planned schedule, pressure reduction support surface, foam wedges for 30 degree lateral positioning, manage moisture, offer bedpan/urinal and a glass of water in conjunction with turning schedules, increase protein intake, offer liquid diet supplement, manage friction and shear, and use lift sheet to move patient. Patient #3 was lactose intolerant and allergic to red dye, diphenhydramine, and tuberculosis serum. Review			

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	of nutritional requirements included a regular diet with soft foods. The patient wore briefs for incontinence of bowel and bladder, and had reflux/indigestion. Review of the male reproductive system evidenced "NA, no problems reported." Patient #3 was unable to ambulate and had paralysis to the left upper and lower extremities, was able to creep, roll, sit supported, and pull up to stationary objects. The patient used a manual wheelchair for primary mobility with AFOs in place when in the wheelchair. The patient was non-verbal with developmental delay, recognized family and caregivers, and his name. The patient had a VNS (Vagal Nerve Stimulator) and experienced over 1000 seizures per month. A detailed seizure plan was present. The PHQ-2 depression screen evidenced no depression or suicide ideation. The assessment failed to be appropriate for pediatric patients and failed to include the patient's diagnoses pertinent to the reason for home health. The fall risk assessment and risk for hospitalization failed to include risks related the patient's developmental delays, osteoporosis, hemiparesis (mild or partial weakness or loss of strength on one side of the body), pulling up to objects, and poor mobility, and evidenced environmental hazards followed but evidenced no environmental hazards in another section. It also failed to address how the patient was transferred safely, the specific fall prevention plan, and the education provided. The assessment failed to evidence an appropriate assessment tool for a 2 year old, as the FLACC pain assessment tool is indicated for use with newborns through age 7, and failed to utilize an appropriate pressure sore assessment as the Braden Scale is indicated for use with adults vs the Braden Q Scale for pediatric patients. The interventions for skin integrity failed			

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	to be appropriate for the patient based on age, development, mobility, and nutritional intake. The assessment failed to include the symptoms and interventions for the patient's listed allergies and failed to include the patient's atopic dermatitis interventions. The assessment failed to include assessment of the patient's genitals related to age and onset of puberty, failed to include how patient #3 communicated and made needs known, whether the patient could propel the wheelchair, what type of seizures the patient had and how to respond to the individual types, whether the patient was able to perform any personal care/dressing/grooming. It failed to address the patient's educational status and developmental, cognitive, and emotional needs and failed to address age/developmental appropriate behavior and discipline, and exercise/therapy required to assist the patient in continued milestones. The nutritional assessment failed to include foods/reasons associated with vomiting (see interview below) and how to stop the vomiting if it started. The assessment failed to assess an accurate weight and height, and failed to address the growth and development for pediatric patients, and failed to include complete and accurate assessment for patient #1's health, psychosocial, functional, and cognitive status. 3. On 6/9/21 at 3:30 PM, the administrator and clinical manager were interviewed concerning pediatric comprehensive assessments. When queried if the agency used pediatric assessments, they stated the agency used a non-OASIS (Outcome and Assessment Information Set) and tailored it for pediatric patients via their electronic medical record software. When queried whether that included items specific to pediatric growth and development (example: head circumference, developmental play, language development, toilet			

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	training) they stated it did not, but they were now aware of the difference between adult and pediatric assessments and would review content and availability of assessments designed for pediatric patients. No further information was provided. 410 IAC 17-14-1(a)(1)(B)			
G 0530 Bldg. 00	484.55(c)(2) Strengths, goals, and care preferences The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; Based on record review and interview, the agency failed to ensure all patients received an age-appropriate comprehensive assessment that accurately reflected the patient's health, psychosocial, functional, and cognitive status in 2 of 4 active records reviewed. (Patients #1, 3) Findings include: 1. Review of the clinical record for patient #1 revealed a comprehensive assessment titled "ROC/RCT (Resumption of care/Recertification) Assessment - Non-OASIS, dated 5/6/21 at 5 PM - 5:30 PM. The assessment revealed the patient was a mobile, 2 year old toddler The assessment failed to evidence specific care preferences including, but not limited to favorite toys, preferred methods of soothing, daily schedules, likes and dislikes, appropriate discipline, and favorite "pleasure foods", favorite and allowed	G 0530	The Agency has created a pediatric assessment form for patients 17 and under, adapted from the Briggs Comprehensive Pediatric Assessment form. All nurses responsible for completing the comprehensive assessment have been in-serviced on the new assessment form, as well as the requirement to accurately document the patient's health, psychosocial, functional, and cognitive status within the assessment form. All comprehensive assessments for patients 17 years of age and under will be completed using this new form, effective immediately. All incoming nurses responsible for completing comprehensive	07/02/2021

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	television shows and movies, and favorite music. 2. During a home visit on 6/8/21 from 9 AM - 11 AM, patient #3 was observed seated in the floor watching television. The patient's grandmother (his legal guardian and referred to as his mother), was present in the home and was interviewed during this visit. The surveyor observed gates securing the patient from the kitchen and bedroom area, as well as many appropriate toys in the room. The patient's grandmother stated patient #3 required snacks every 2 hours, had a history of poor weight gain, and was able to feed himself finger foods but was always supervised because he would stuff his mouth and vomit or choke. Grandmother stated she prepared the patient's food for each day prior to leaving for work so she could manage portions. The patient had a special "spinning chair" used during eating. The grandmother stated the patient had just received new AFOs, worn only with shoes, however the patient would not wear shoes and socks. When able to make him wear shoes, he required zip shoes. The patient was observed scooting on his bottom as a preferred means of mobility. The patient's grandmother stated she bathed the patient and did not have the nurses do it so that she could "control the drying" due to the atopic dermatitis. The patient had a Hoyer lift but was frightened of it and "fights it". The grandmother stated the patient received services 7 - 11 hours per day depending on her work schedule and the number of appointments patient #3 had that week, including medical and therapy appointments. The grandmother stated the nurses must watch the patient's face and body for cues to how the patient feels because the patient was unable to make needs known in any other way. Review of the clinical record for patient #3		assessments will be oriented to the pediatric assessment form upon hire. The Director of Clinical Services will audit 100% of pediatric patient assessments for a period of 30 days to ensure 100% compliance with the new form. After 30 days, the Director of Clinical Services will review pediatric patient assessments in the Agency's quarterly 10% clinical record audit, as part of the Agency's QAPI Program to ensure continued compliance. The Director of Clinical Services is responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur. The Administrator and Director of Clinical Services are responsible for monitoring the corrective actions to ensure the deficiency is corrected and will not recur. Completed 7/02/2021 and ongoing.	

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	revealed a "ROC/RCT Comprehensive Assessment - Non-OASIS, dated 4/29/21 from 9:10 AM - 10:00 AM. The assessment failed to include the specific care preferences stated by the grandmother during the home visit including, but not limited to, appropriate toys and developmental activities, specific therapy/exercises, special shoes, the patient's fear of the Hoyer lift, favorite toys or items that sooth, the need for gates to be secured, that only grandmother bathed patient #3, the spinning chair, the preferred means of mobility at home, and facial and body cues which evidenced patient #3's needs.			
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 or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on observation, record review and interview, the agency failed to ensure plan of care was individualized for 1 of 4 active records reviewed (Patient 2). Findings include: Review of an agency policy dated 12/30/20 titled, "Plan of Care C580" stated, "...Special Instructions	G 0572	The frequency and duration for patient #2 has been re-written to be specific to that patient's schedule. The Director of Clinical Services has conducted a focused audit for 100% of agency patients to ensure all frequency and duration statements are individualized to	07/02/2021

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	... 2. The Plan of care shall be completed in full to include: ... d. Frequency and duration of visits to be made .... " The clinical record of Patient #2 was reviewed on 6/7/21 and indicated a start of care date of 10/7/15. The record contained a plan of care for the recertification period of 5/8/21 to 7/6/21 with orders for skilled nursing 11-15 hours/day x 4-6 days/week. During an interview on 6/8/21 at 9:10 AM, when queried about her time, Employee E, Skilled Nurse for Patient #2 stated, "I get here everyday Monday through Friday form 5:30 AM to 6:00 PM." During an interview on 6/8/21 at 9:40 AM, with the caregiver of Patient #2, when queried about staffing hours, stated, " I did drive the bus but I hurt my back so I am here [at home] accept for appointments. My daughters help me on the weekends." During an interview with the clinical manager and administrator on 6/9/21 at 4:25 PM, when queried about frequency not being specific and ranges stated, " That is in case they leave early or stay late we have a 2 off range." When queried where the information came from, the administrator reported from their deemed accrediting agency. 410 IAC 17-13-1(a)(1)(D)(iii)		each patient. All records are 100% compliant. All nurses responsible for developing plans of care have been re-educated on the requirement to ensure each patient's plan of care is individualized, including the frequency and duration. The Director of Clinical Services will audit 100% of outgoing plans of care for 30 days to ensure continued compliance at 100%. After 30 days, the Director of Clinical Services will evaluate plans of care during the Agency's 10% quarterly clinical record audit, as part of the Agency's QAPI program. The Administrator and Director of Clinical Services are responsible for monitoring the corrective actions to ensure the deficiency is corrected and will not recur. Completed 7/2/2021 and ongoing.	
G 0584 Bldg. 00	484.60(b)(3)(4) Verbal orders (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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K128	A. BUILDING 00 B. WING	06/14/2021

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	(4) When services are provided on the basis of a physician or allowed practitioner'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 or allowed pracitioner 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 verbal orders were complete and contained specific duties/ services to be provided and failed to ensure the physician was notified after the completion of the comprehensive assessment in 2 of 4 active patients reviewed. (Patients #1, 3) Findings include: 1. A review of the clinical record for patient #1 revealed a document titled "Physician Order for Re-Certification of Services", signed by the clinician and dated 5/6/21 at 10:01 AM. The order evidenced the physician "has been notified of the assessment findings from the recertification visit on 5/5/21. The physician, patient/caregiver, and nurse have collaborated in the development and revision of the plan of care." The document evidenced a verbal order for discipline, frequency, and duration of 1 visit/day x 3-5 days/week x 9 weeks, with no changes to the previously signed plan of care.	G 0584	The recertification verbal order form has been re-configured to contain the specific duties/services to be provided. All nurses responsible for obtaining and documenting orders have been oriented to the new form and have been re-educated on the importance of ensuring the form is completed correctly and the dates on the form accurately reflect the dates of the assessment and order. The Director of Clinical Services will audit 100% of verbal order forms for 30 days to ensure compliance. After 30 days, the Director of Services will incorporate a review of verbal order forms during the Agency's quarterly 10% clinical Record audit, as part of the Agency's QAPI Program to ensure continued compliance.	07/02/2021

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	15K128	A. BUILDING 00 B. WING	06/14/2021

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	Review of the a recertification assessment dated 5/6/21 evidenced the assessment was completed at the patient's home from 5 PM - 5:30 PM. The order failed to include the specific duties and care to be provided during service. The order also evidenced it was established prior to the completion of the comprehensive assessment findings. 2. A review of the clinical record for patient #3 revealed an order for recertification, signed by the clinician and dated 4/28/21 at 12:15 PM. The order evidenced the physician "has been notified of the assessment findings form the certification visit on 4/29/21. The physician, patient/caregiver, and nurse have collaborated in the development and revision of the plan of care." The document evidenced a frequency of 1 visit/day x 3-5 days/week x 9 weeks with no changes to the previous signed plan of care. Review of the recertification assessment dated 5/6/21 evidenced the assessment was completed at the patient's home on 4/29/21 from 9:10 AM - 10 AM. The order failed to include the specific duties and care to be provided during service. The order also evidenced it was established prior to the completion of the comprehensive assessment finding. 3. On 6/14/21 at 3:30 PM the administrator and clinical manager were interviewed concerning the process for obtaining orders for recertification. The clinical manager stated the clinician obtains an order for recertification, then completes the comprehensive assessment, then develops a plan of care which is sent to the physician for		The Administrator and Director of Clinical Services are responsible for monitoring the corrective actions to ensure the deficiency is corrected and will not recur. Completed 7/2/2021 and ongoing.	

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	signature. When queried concerning the point where the clinician reviews the comprehensive assessment findings with the physician, the clinical manager stated it occurs after the assessment and before the plan of care generates. When queried concerning the above orders which showed the clinician contacted the physician to review the assessment findings prior to completing the assessment, the administrator and clinical manager stated they would speak with the case manager concerning why that was done. No further information was provided. 410 IAC 17-14-1(a)(H)			