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	09/20/2018

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 was a Federal recertification survey with a complaint. Complaint #: IN00218965 - Unsubstantiated. Survey Dates: September 12, 13, 14, 20, 2018 Facility #: 013608 Provider #: 15K128 Medicaid #: 201279300 Unduplicated Census: 247 (8 Skilled and 232 Home health aide only)	G 0000	No Response Required	
G 0574 Bldg. 00	Based on record review and interview, the agency failed to ensure the plan of care included frequency and duration for the skilled nurse interventions and supervisory visits for 3 of 5 active patients records(#1, 4, 5) and 2 of 2 closed patients records (#6, #7). Finding include: 1. An agency policy titled, "Plan of Care C-580" was reviewed and stated "Special Instructions: ...2. The Plan of Care shall be completed in full to include: ... c. Type, frequency, and duration of all visits/ services." 2. An agency policy titled, "Supervisory Visit of	G 0574	The Director of Clinical Services has instructed every Clinical Supervisory to include the frequency and duration for the supervisory visits on every Plan of Care/485. The Director of Clinical Services and the Clinical Supervisors will be including the frequency and duration of the supervisory visits on every recertification POC due by October 20, 2018. For those files that have recertifications outside of the 30 day correction date, October 20, 2018, there will be a corrective supplemental order written for that POC/485.	10/20/2018

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

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	09/20/2018

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	Patient/ Staff C-315" was reviewed and stated "Special Instructions: ... 2. If patients are receiving only home health aide services and there is no skilled services provided, the Registered Nurse will make a supervisory visit to the patient's residence at least every thirty (30) days." 3. The agency provide document titled "Home Health Certification and Plan of Care" for patient #1 indicated skilled Nursing vital signs, interventions including: parameters for notifying the physician; skilled nursing assessment interventions including: education for bleeding precautions; comprehensive assessment, and monitoring of falls. The record failed to evidence the frequency and duration for the skilled nurse visits, and failed to evidence frequency of supervisory visits for the home health aide. 4. The agency provide document titled "Home Health Certification and Plan of Care" for patient #4 indicated skilled Nursing vital signs, interventions including: parameters for notifying the physician; skilled nursing assessment interventions including: education for pain precautions and ostomy care; comprehensive assessment, monitoring of falls, and depression. The record failed to evidence the frequency and duration for the skilled nurse visits, and failed to evidence frequency of supervisory visits for the home health aide. 5. The agency provide document titled "Home Health Certification and Plan of Care" for patient #5 indicated skilled Nursing vital signs, interventions including: parameters for notifying the physician; skilled nursing assessment interventions including: education for fall precautions and standard precautions;		The Director of Clinical Services and/or designee will audit a minimum of 10% of charts quarterly for evidence that the frequency and duration for supervisory visits has been included in the Plan of Care. The Director of Clinical Services and the Clinical Supervisors will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	15K128	A. BUILDING 00 B. WING	09/20/2018

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	comprehensive assessment, and monitoring of falls and safety. The record failed to evidence the frequency and duration for the skilled nurse visits, and failed to evidence frequency of supervisory visits for the home health aide. 6. The agency provide document titled "Home Health Certification and Plan of Care" for patient #6 indicated skilled Nursing vital signs, interventions including: parameters for notifying the physician; skilled nursing assessment interventions including: education for fall precautions and pain prevention; comprehensive assessment, and monitoring for depression. The record failed to evidence the frequency and duration for the skilled nurse visits, and failed to evidence frequency of supervisory visits for the home health aide. 7. The agency provide document titled "Home Health Certification and Plan of Care" for patient #7 indicated skilled Nursing vital signs, interventions including: parameters for notifying the physician; skilled nursing assessment interventions including: education for fall prevention and safety, bleeding, and depression; comprehensive assessment, diabetic foot exam, including: skin inspection and monitoring for depression. The record failed to evidence the frequency and duration for the skilled nurse visits, and failed to evidence frequency of supervisory visits for the home health aide. 8. During an interview on 9/14/18 at 4:12 PM, the Administrator and Director of Nursing (DON) were asked if they considered education or educating the patient a skill; to which they replied "No." The Administrator indicated that the education provided was only provided as needed or by the patients' request, not regularly.			

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G 0682 Bldg. 00	Based on observation, record review, and interview, the agency failed to ensure all staff practiced proper hand hygiene, and followed infection control policies and procedures for 2 of 3 (#2, and 3) home visit observations conducted. Findings include: 1. An undated agency policy titled, "Handwashing/Hand Hygiene D-330" was reviewed and stated "Policy: ... thorough hand washing antisepsis is required of all employees. ...Special Instructions: ...3. Indications for hand washing and hand antisepsis: ... d. Between task on the same patient. ... f. After removing gloves. g. After touching objects that are potentially contaminated. k. After assisting patient to use the bathroom. l. Before eating, drinking, handling food, or serving food. ... n. ... use an alcohol-based rub for routinely decontaminating hands in all other clinical situations. ... p. Decontaminate hands after contact with patient's skin, after contact with body fluids, excretions, non-intact skin, and wound dressings. q. ...after contact with inanimate objects including equipment in immediate vicinity of the patient. r. ... after removing gloves. ... Hand Hygiene Technique: 1. ... with an alcohol based hand rub, apply product to palm one hand, and rub hands together ... 2. When washing hands with soap and water ... apply amount of product ... to hands and rub hands together vigorously for at least 15 (fifteen) seconds." 2. An undated agency policy titled, "Infection Prevention/Control B-403" was reviewed and	G 0682	The employees who were noted during the recent ISDH survey to incorrectly perform hand hygiene and infection control practices have received individual education and counseling by the Director of Clinical Services to ensure that their practices have immediately improved and are in compliance with agency policy and acceptable standards. The Director of Clinical Services has educated Home Health Aides, Certified Nursing Assistants, Skilled Nurses, and Clinical Supervisors to Centers for Disease Control standards for hand washing and infection control. In addition, the Clinical Supervisors will observe and assess the staff's ability to perform appropriate hand washing and infection control practices on every supervisory visit. This will be documented on the supervisor visit note under the heading of: "Employee is following infection prevention and control". The Infection Control in-service will be given annually to all Home Health Aides and Certified Nursing Assistants. Upon hire all new employees will receive an in-service at orientation to ensure proper hand washing and infection control technique. The Director of Clinical Services	10/20/2018

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	stated "Standard Precautions - Tier One: Standard precautions apply to blood, all body fluids, secretions, excretions, non-intact skin, and mucous membranes. All are to be treated as a potential source of infection regardless of whether the patient has a communicable disease. 3. Hands are washed ... immediately after gloves are removed, between patient contacts, and ... between other patients or the environment. 4. Gloves are worn when touching ...body fluids, ... non-intact skin, mucous membranes, or contaminated items." 3. During a home visit for patient #2 on 9/13/18 at 09:18 AM, employee E; an LPN (Licensed Practical Nurse) was observed providing personal care services. At 09:24 employee E was observed washing her hands for 9 seconds then drying her hands on a cloth towel. The LPN then filled the basin with water, took the basin to the bedroom, and placed it on the changing table. At 9:26 AM, the LPN went to the living room and took patient #2 from her highchair and to the bedroom where she was placed on the changing table and her pajamas were removed down to the diaper. At 09:31 AM, as the LPN attempted to flush patient #2's G-tube (gastrointestinal tube) the tube came out from the site. While holding patient #2 on the changing table with her right hand, the LPN reached for a new G-tube placement kit in the changing drawer, opened the kit, obtained a new G-tube "Mickey" button, placed the "Mickey" button, and anchored the button with water keep it's placement. The LPN proceeded to clean around the G-tube site with a washcloth and water, applied topical ointment around the stoma, and placed a 2X2 drain sponge with silk tape around the stoma. The LPN continued by washing patient #2's face, eyes, ears, and hands with the same cloth. The LPN changed the diaper,		and/or designee(s) will audit a minimum of 10% of charts quarterly for evidence of documentation of teaching and observation of appropriate hand washing and infection control practices. The Director of Clinical Services and Clinical Supervisors will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	whipped, and dried the perineal area, and applied a new diaper and clothes. The LPN then took patient #2 back to the living room and placed her on the couch. Employee E was never observed donning gloves or sanitizing her hands after the first hand washing observation. Employee E failed to follow standard precautions and hand hygiene per agency policy. 4. During a home visit for patient #3 on 9/14/18, at 08:37 a Registered Nurse (RN); employee D sanitized her hands, donned gloves, obtained a snack for patient #3 from the refrigerator with her left hand, and then removed the left glove and donned a new glove. The RN proceeded to prepare the medications; on the counter, for administration. At 08:54 AM, the RN assisted patient #3 with her inhaler. Afterwards, the RN removed the left glove, donned a new glove, and prepared a 2X2 grain sponge with ointment, and applied in to the G-tube stoma. The RN removed both gloves, sanitized hands and donned new gloves. At 08:59 AM, The RN prepared a syringe with PolyVisol, inserted the syringe into the G-tube "Mickey" button and flushed the medication with 7 ml (milliliters) of water. The RN continued by removing the left glove, donning a new glove, and administering nasal spray in both nares. The RN placed the spray in the supply closet, removed both gloves and sanitized hands. Employee D failed to follow standard precautions and consistent hand hygiene per agency policy. 5. During an interview on 9/20/18 at 5:15 PM, the Director of Nursing (DON); employee B was asked when staff should wash their hands during a home visit. The DON replied "Before and after patient contact, after contact with contaminated items or body fluids, and after removing gloves." The DON was then asked how long staff should			

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	wash their hands; to which she replied, "Fifteen (15) seconds is our policy."			
N 0000 Bldg. 00	This was a State re-lincesure survey with a complaint. Complaint #: IN00218965 - Unsubstantiated. Survey Dates: September 12, 13, 14, 20, 2018 Facility #: 013608 Provider #: 15K128 Medicaid #: 201279300 Unduplicated Census: 247 (8 Skilled and 232 Home health aide only)	N 0000	No Response Required	
N 0470 Bldg. 00	410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, record review and interview, the agency failed to ensure all staff practiced proper hand hygiene, and followed infection control policies and procedures for 2 of 3 (#2, and 3) home visit observations conducted. Findings include: 1. An undated agency policy titled,	N 0470	The employees who were noted during the recent ISDH survey to incorrectly perform hand hygiene and infection control practices have received individual education and counseling by the Director of Clinical Services to ensure that their practices have immediately improved and are in compliance with agency policy and acceptable	10/20/2018

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	"Handwashing/Hand Hygiene D-330" was reviewed and stated "Policy: ... thorough hand washing antisepsis is required of all employees. ...Special Instructions: ...3. Indications for hand washing and hand antisepsis: ... d. Between task on the same patient. ... f. After removing gloves. g. After touching objects that are potentially contaminated. k. After assisting patient to use the bathroom. l. Before eating, drinking, handling food, or serving food. ... n. ... use an alcohol-based rub for routinely decontaminating hands in all other clinical situations. ... p. Decontaminate hands after contact with patient's skin, after contact with body fluids, excretions, non-intact skin, and wound dressings. q. ...after contact with inanimate objects including equipment in immediate vicinity of the patient. r. ... after removing gloves. ... Hand Hygiene Technique: 1. ... with an alcohol based hand rub, apply product to palm one hand, and rub hands together ... 2. When washing hands with soap and water ... apply amount of product ... to hands and rub hands together vigorously for at least 15 (fifteen) seconds." 2. An undated agency policy titled, "Infection Prevention/Control B-403" was reviewed and stated "Standard Precautions - Tier One: Standard precautions apply to blood, all body fluids, secretions, excretions, non-intact skin, and mucous membranes. All are to be treated as a potential source of infection regardless of whether the patient has a communicable disease. 3. Hands are washed ... immediately after gloves are removed, between patient contacts, and ... between other patients or the environment. 4. Gloves are worn when touching ...body fluids, ... non-intact skin, mucous membranes, or contaminated items."		standards. The Director of Clinical Services has educated Home Health Aides, Certified Nursing Assistants, Skilled Nurses, and Clinical Supervisors to Centers for Disease Control standards for hand washing and infection control. In addition, the Clinical Supervisors will observe and assess the staff's ability to perform appropriate hand washing and infection control practices on every supervisory visit. This will be documented on the supervisor visit note under the heading of: "Employee is following infection prevention and control". The Infection Control in-service will be given annually to all Home Health Aides and Certified Nursing Assistants. Upon hire all new employees will receive an in-service at orientation to ensure proper hand washing and infection control technique. The Director of Clinical Services and/or designee(s) will audit a minimum of 10% of charts quarterly for evidence of documentation of teaching and observation of appropriate hand washing and infection control practices. The Director of Clinical Services and Clinical Supervisors will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and	

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	3. During a home visit for patient #2 on 9/13/18 at 09:18 AM, employee E; an LPN (Licensed Practical Nurse) was observed providing personal care services. At 09:24 employee E was observed washing her hands for 9 seconds then drying her hands on a cloth towel. The LPN then filled the basin with water, took the basin to the bedroom, and placed it on the changing table. At 9:26 AM, the LPN went to the living room and took patient #2 from her highchair and to the bedroom where she was placed on the changing table and her pajamas were removed down to the diaper. At 09:31 AM, as the LPN attempted to flush patient #2's G-tube (gastrointestinal tube) the tube came out from the site. While holding patient #2 on the changing table with her right hand, the LPN reached for a new G-tube placement kit in the changing drawer, opened the kit, obtained a new G-tube "Mickey" button, placed the "Mickey" button, and anchored the button with water keep it's placement. The LPN proceeded to clean around the G-tube site with a washcloth and water, applied topical ointment around the stoma, and placed a 2X2 drain sponge with silk tape around the stoma. The LPN continued by washing patient #2's face, eyes, ears, and hands with the same cloth. The LPN changed the diaper, whipped, and dried the perineal area, and applied a new diaper and clothes. The LPN then took patient #2 back to the living room and placed her on the couch. Employee E was never observed donning gloves or sanitizing her hands after the first hand washing observation. Employee E failed to follow standard precautions and hand hygiene per agency policy. 4. During a home visit for patient #3 on 9/14/18, at 08:37 a Registered Nurse (RN); employee D sanitized her hands, donned gloves, obtained a snack for patient #3 from the refrigerator with her		will not recur.	

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	left hand, and then removed the left glove and donned a new glove. The RN proceeded to prepare the medications; on the counter, for administration. At 08:54 AM, the RN assisted patient #3 with her inhaler. Afterwards, the RN removed the left glove, donned a new glove, and prepared a 2X2 grain sponge with ointment, and applied in to the G-tube stoma. The RN removed both gloves, sanitized hands and donned new gloves. At 08:59 AM, The RN prepared a syringe with PolyVisol, inserted the syringe into the G-tube "Mickey" button and flushed the medication with 7 ml (milliliters) of water. The RN continued by removing the left glove, donning a new glove, and administering nasal spray in both nares. The RN placed the spray in the supply closet, removed both gloves and sanitized hands. Employee D failed to follow standard precautions and consistent hand hygiene per agency policy. 5. During an interview on 9/20/18 at 5:15 PM, the Director of Nursing (DON); employee B was asked when staff should wash their hands during a home visit. The DON replied "Before and after patient contact, after contact with contaminated items or body fluids, and after removing gloves." The DON was then asked how long staff should wash their hands; to which she replied, "Fifteen (15) seconds is our policy."			
N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:			

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	(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review and interview, the agency failed to ensure the plan of care included frequency and duration for the skilled nurse interventions and supervisory visits for 3 of 5 active patients records(#1, 4, 5) and 2 of 2 closed patients records (#6, #7). Finding include: 1. An agency policy titled, "Plan of Care C-580" was reviewed and stated "Special Instructions: ...2. The Plan of Care shall be completed in full to include: ... c. Type, frequency, and duration of all visits/ services." 2. An agency policy titled, "Supervisory Visit of Patient/ Staff C-315" was reviewed and stated "Special Instructions: ... 2. If patients are receiving only home health aide services and there is no skilled services provided, the Registered Nurse will make a supervisory visit to the patient's residence at least every thirty (30)	N 0524	The Director of Clinical Services has instructed every Clinical Supervisory to include the frequency and duration for the supervisory visits on every Plan of Care/485. The Director of Clinical Services and the Clinical Supervisors will be including the frequency and duration of the supervisory visits on every recertification POC due by October 20, 2018. For those files that have recertifications outside of the 30 day correction date, October 20, 2018, there will be a corrective supplemental order written for that POC/485. The Director of Clinical Services and/or designee will audit a minimum of 10% of charts quarterly for evidence that the frequency and duration for	10/20/2018

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	days." 3. The agency provide document titled "Home Health Certification and Plan of Care" for patient #1 indicated skilled Nursing vital signs, interventions including: parameters for notifying the physician; skilled nursing assessment interventions including: education for bleeding precautions; comprehensive assessment, and monitoring of falls. The record failed to evidence the frequency and duration for the skilled nurse visits, and failed to evidence frequency of supervisory visits for the home health aide. 4. The agency provide document titled "Home Health Certification and Plan of Care" for patient #4 indicated skilled Nursing vital signs, interventions including: parameters for notifying the physician; skilled nursing assessment interventions including: education for pain precautions and ostomy care; comprehensive assessment, monitoring of falls, and depression. The record failed to evidence the frequency and duration for the skilled nurse visits, and failed to evidence frequency of supervisory visits for the home health aide. 5. The agency provide document titled "Home Health Certification and Plan of Care" for patient #5 indicated skilled Nursing vital signs, interventions including: parameters for notifying the physician; skilled nursing assessment interventions including: education for fall precautions and standard precautions; comprehensive assessment, and monitoring of falls and safety. The record failed to evidence the frequency and duration for the skilled nurse visits, and failed to evidence frequency of supervisory visits for the home health aide.		supervisory visits has been included in the Plan of Care. The Director of Clinical Services and the Clinical Supervisors will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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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
	6. The agency provide document titled "Home Health Certification and Plan of Care" for patient #6 indicated skilled Nursing vital signs, interventions including: parameters for notifying the physician; skilled nursing assessment interventions including: education for fall precautions and pain prevention; comprehensive assessment, and monitoring for depression. The record failed to evidence the frequency and duration for the skilled nurse visits, and failed to evidence frequency of supervisory visits for the home health aide. 7. The agency provide document titled "Home Health Certification and Plan of Care" for patient #7 indicated skilled Nursing vital signs, interventions including: parameters for notifying the physician; skilled nursing assessment interventions including: education for fall prevention and safety, bleeding, and depression; comprehensive assessment, diabetic foot exam, including: skin inspection and monitoring for depression. The record failed to evidence the frequency and duration for the skilled nurse visits, and failed to evidence frequency of supervisory visits for the home health aide. 8. During an interview on 9/14/18 at 4:12 PM, the Administrator and Director of Nursing (DON) were asked if they considered education or educating the patient a skill; to which they replied "No." The Administrator indicated that the education provided was only provided as needed or by the patients' request, not regularly.			