STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K167	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAPTIVE NURSING AND HEALTHCARE	**6602 E 75TH STREET STE 230 , 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 Provider. Survey Dates: 8/9/21 - 8/16/21 Complaint: #IN00335004/29891 - Substantiated. Federal and State deficiencies were cited Complaint: #IN00317988/29893 - Substantiated. No Federal or State deficiencies were cited. Complaint: #IN00316012/29892 - Substantiated. Federal and State deficiencies were cited. Complaint: #IN00333042/29894 - Substantiated. Federal and Stated deficiencies were cited. Facility ID: 014118 Provider/CCN Number: 15K167 Census: 165 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. Quality Review Completed 9/22/21 by Area 3	G0000		
G0482	Mistreatment, neglect or abuse CFR(s): 484.50(e)(1)(i)(B) (i)(B) Mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the HHA.	G0482		

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

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G0482	Continued from page 1 This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure an assessment was conducted by a registered nurse when allegations of abuse were reported for 1 of 1 record reviewed of reported abuse. (Patient #4) Findings include: A review of the “Grievance Log, Greenwood”, revealed a documented complaint about patient #4, dated 7/7/21, which stated “Client family called stating caregiver hurt client. [Name of Employee P] (an HHA) was the accused caregiver." A review of the clinical record for patient #4 contained home health aide visit notes dated 6/29/21, 7/1/21, and 7/2/21, which revealed patient #4 was provided services by Employee P, a home health aide. A new home health aide was sent to the home on 7/5/21. On 7/13/21 the patient's case manager contacted the patient's daughter to arrange a recertification visit and was notified of the patient's fracture. The daughter stated the patient had a fracture of the right greater trochanter and was placed on Percocet. The nurse completed an incident report on 7/13/21. The clinical record and the complaint investigation failed to evidence that an assessment of the patient was completed when the abuse was reported on 7/7/21. On 8/13//21 at 3:30 PM, the administrator was queried concerning how the investigation was managed for patient #4 and stated, "We weren't even told until a couple of weeks after it happened." The administrator further stated that the patient's daughter did not call the agency until 7/7/21, and there was no bruising. The administrator denied speaking with the patient or family and stated the patient was assessed in the emergency department when the injury occurred. 410 IAC 17-12-2(f)	G0482		
G0484	Document complaint and resolution CFR(s): 484.50(e)(1)(ii) (ii) Document both the existence of the complaint	G0484		

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G0484	Continued from page 2 and the resolution of the complaint; and This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure all complaints were resolved and resolutions were documented for 1 of 3 active patient complaints reviewed (patient #4), and 2 of 3 discharged patient complaints reviewed. (Patients #10, 11, 12) Findings include: 1. Review of an agency policy titled "Identifying and Reporting Abuse/Neglect/Exploitation, last revised 3/8/18, indicated agency responsibilities included admission of clients who can be cared for safely, providing staff education, review of patient's vulnerability assessment, maintain and retain a record of all vulnerable patients, and maintain client confidentiality. The policy failed to include a process for managing complaints, including how complaints are investigated, how the patient is kept safe during investigation, patient notification of resolution, and documentation of the complaint and resolution. 2. Review of a booklet titled “Patient Orientation for Home Health Care” indicated the agency’s “Problem Solving Procedure”, The document also indicated a subsection titled “Quality of Care” which stated, “The Administrator/Director shall document both the existence of the complaint and the resolution of the complaint, investigate the complaint and report the outcome of the investigation to the patient or their representative.” 3. Review of the “Grievance Log, Greenwood”, revealed a documented complaint for patient #4, dated 7/7/21, which stated “Client family called stating caregiver hurt client. [Name of Employee P] (an HHA) was the accused caregiver." The administrator signed the complaint on 7/30/21. The complaint resolution date was blank. 4. Review of a complaint report dated 4/9/21, for patient #10, now discharged, revealed the resolution was blank, patient informed was blank, patient satisfied was blank, and the final resolution was blank. The agency failed to	G0484		

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G0484	Continued from page 3 complete a full investigation which included documentation of the complaint resolution, when the patient was notified, and whether the patient was satisfied. During an interview on 8/12/21 at 4:00 PM, person E, the patient's daughter, stated she had not received any communication from the agency concerning resolution of the complaint, and wondered if the aide was still providing services to other people. The daughter also stated she was told by employee C, an RN and branch manager for the Greenwood office, that "corporate was handling everything and it is out of our hands." The daughter stated neither the patient nor any family members have been contacted by anyone at "corporate." During an interview on 8/13/21 at 3:30 PM, the administrator stated the complaint involving patient #4 had "been given to corporate." The administrator stated she thought that once the information was given to the corporate lawyers and corporate compliance individuals, she was no longer responsible to follow up on the compliant, as she expected "corporate" to do so. 5. Review of a complaint report dated 5/21/21, for patient #11, now discharged, revealed the section for complaint reviewed by administrator/supervising nurse was blank. 6. Review of a complaint report dated 6/11/21, for patient #12 (discharged from Medicaid Prior Authorization services - a type of Medicaid coverage – on 7/9/21), revealed findings, resolution, patient informed of resolution, patient satisfied, and final resolution sections were blank. 410 IAC 17-14-1(g)	G0484		
G0544	Update of the comprehensive assessment CFR(s): 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and	G0544		

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G0544	Continued from page 4 revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- This STANDARD is NOT MET as evidenced by: Based on record review an interview, the agency failed to ensure that the comprehensive assessment was updated after a change in condition for 1 of 1 patient reviewed for a complaint of injury due to suspected abuse and injury of unknown source. (Patient #4) Findings include: Review of a policy titled "Comprehensive Client Assessment", last revised 4/29/20, indicated "The Comprehensive Assessment will be updated and revised as often as the client's condition warrants due to major decline or improvement in health status ... Clients are reassessed when significant changes occur in their condition. Clients are reassessed when significant changes occur in their diagnosis." A review of the patient's clinical record, complaint logs, incident logs, and emails provided by the administrator evidenced the agency received a complaint from the patient's daughter on 7/7/21. The daughter stated the patient had a fracture of the right greater trochanter. On 7/13/21 the patient's case manager contacted the patient's daughter to arrange a recertification visit and was notified of the patient's fracture. The nurse completed an incident report on 7/13/21, which stated she notified the physician. The nurse failed to immediately complete a comprehensive reassessment due to a change in condition and scheduled a visit for a recertification assessment on 7/15/21. On 8/13/21 at 12:39 PM, employee M, the RN (Registered Nurse) case manager was interviewed concerning patient #4. The nurse stated she did not complete a comprehensive assessment when notified of the patient's injury because the agency's policy said as long as the patient was seen by a medical professional, such as the physician, EMS (Emergency Medical Services), or in the emergency department, it counted as the assessment. Employee M stated they completed an incident report and contacted the patient's	G0544		

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G0544	Continued from page 5 physician. On 8/13//21 at 3:30 PM, the administrator was questioned about the agency policy for reassessment. The administrator agreed with the case manager and stated as long as the patient was seen by a medical professional, it counts as the assessment. 410 IAC 17-14-1(a)(1)(E)	G0544		
G0572	Plan of care CFR(s): 484.60(a)(1) 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. This STANDARD is NOT MET as evidenced by: Based on record review, and interview the agency failed to adhere to the discipline specific visit frequency as ordered in the plan of care (POC) for 5 of 9 records reviewed. (Patients #1, 5, 7, 8, 9) Findings include: 1. The clinical record for patient #1's, the start of care 5-19-20, was reviewed on 8-10-21. The clinical record contained a plan of care for the certification period of 5-19-20 to 7-17-20, with orders for Home Health Aide services 8 hours a day, 7 days a week for 60 days. The primary diagnosis was Dementia without behavioral disturbances (patient loses the agility to think, remember, learn, make decisions and solve problems). The clinical record indicated visit times to scheduled from 9:00 to 5:00 PM. The clinical record indicated the patient is non-ambulatory and transfer to a wheelchair per Hoyer lift. A review of the home health aide visit notes, the	G0572		

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G0572	Continued from page 6 following dates of services failed to be provided as ordered: 5-24-20, 5-29-20, 5-30-20, 5-31-20, 6-28-20, and visits were missed on 6-14-20 and 7-5-20 due to the agency's inability to staff. During an interview on 8-10-21 at 11:45 AM, Person D, family member and Power of Attorney for Patient #1, indicated when they called the agency to complain that someone didn't show or had a concern over Patient #1's care, they felt the office staff was rude to them. Person D indicated the aide was supposed to bathe, dress, and feed patient #1's their pureed diet. Person D indicated someone was supposed to be there from 9:00 AM to 5 PM for his PA (Prior Authorization) aide. Person D indicated the weekend coverage was "the worst" and indicated the agency blamed the "industry". Person D indicated they knew someone who is a Certified Nurse Aide and has been paying them to come and care for patient #1 privately. Person D indicated again, how the office was rude, wasn't compassionate and they would get agitated. Person D indicated the clinical supervisor came out and made statements that sounded good but they had no choices. Person D indicated they would wait several times for a staff person to not show, be late or leave early before they would express their concerns. During an interview on 8-12-21 at 1:07 PM, Person B, case manager at CICOA was interviewed. Person B indicated Person D needed 8:00 AM to 4:00 PM shift and Adaptive would do 9:00 AM to 5:00 PM. Adaptive notified Person B they were having difficulties filling the shifts. Person B indicated it took some searching and Person D meeting several agencies before finding one that fit the client and caregiver's needs. 2. The clinical record for patient #5, start of care 1-26-21, was reviewed and contained a plan of care for the certification period of 7-25-21 to 9-22-21, with orders for home health aide services 7 days a week for 6 hours per day to assist with personal care, meal preparation, medication reminders, and light housekeeping. The plan of care indicated the patient's diagnosis is kyphosis (excessive outward curvature of the spine). Further review of patient #5's clinical record failed to evidence home health aide visits were completed for the following visits: Week 1: July 31st, 2021.	G0572		

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G0572	Continued from page 7 Week 2: August 2nd, 4th, 2021 Week 3: August 9th, 2021. During an interview with Patient #5 on 8-13-2021 at 1:30 p.m., he/she reported that he/she does not have an aide about "1/3" of the time. When queried what he/she does for assistance on the days there is not a home health aide from Adaptive to help him/her, he/she reported that his/her grandson assists her. 3. The clinical record for patient #7, start of care 6-30-21, was reviewed and contained a plan of care for the certification period of 6-30-21 to 8-28-21, with orders for a home health aide services 2 hours per day 5 days a week. The plan of care indicated the patient's diagnosis was diabetes mellites, generalized weakness, ataxia (impaired balance or coordination, gait (the manner of walking or moving), and tremor (involuntary shaking or movement). The clinical record patient #7 failed to evidence home health aide visits were completed for the following visits: Week 1: 8 hours home health aide services were missed Week 2: 2 hours of home health aide services were missed Week 3: 4 hours of home health aide services were missed Week 4: 4 hours of home health aide services were missed. 4. The clinical record for patient #8, start of care 8-25-2020, was reviewed and contained a plan of care for the certification period of 6-21-21 to 8-19-21, with orders for home health aide services 3 hours per day, 4-5 days a week. The plan of care indicated the patient's diagnosis was, chronic obstructive pulmonary disease, hypertension, gastroesophageal reflux disease, muscle weakness, and dorsalgia (back pain). Care plan orders include assistance with personal care, meal prep, medication reminders, and light housekeeping. Clinical record for patient #8 failed to evidence home health aide visits were completed for the following: Week1: 6 hours of home health aide services were	G0572		

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G0572	Continued from page 8 missed Week 2: 12 hours of home health aide services were missed Week 3: 3 hours of home health aide services were missed Week 5: 6.75 hours of home health aide services were missed. Week 6: 4. 5 hours of home health aide services were missed. 5. The clinical record for patient # 9, start of care 7-13-19, was reviewed and contained a plan of care for the certification period of 7-6-21 to 9-3-21, with orders for home health aide services 3 hours per day for 5 days a week to assist with personal care, meal prep, medication reminders, and light housekeeping. The plan of care indicated the patient's diagnosis was Down Syndrome (a wide range of developmental and physical disabilities caused by a genetic disorder). Further review of patient #9's clinical record failed to evidence home health aide visits were completed for the following visits: Week 1: July 14,15, 2021 Week 2: July 19, 2021 Week 5: August 8 to 13th, 2021 410 IAC 7-14-1(e)	G0572		
G0590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the physician was notified of a significant change in condition for 1 of 1 active patients reviewed for a complaint of suspected abuse.	G0590		

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G0590	Continued from page 9 Findings Include: 1. Review of the agency complaint log revealed a complaint on 7/7/21, placed by a family member of patient #4, who stated the patient had been experiencing severe pain since 7/3/21 and accused the home health aide of hitting her with a fist. A CT scan (computed tomography - a type of x-ray) done at the hospital on 7/6/21 indicated the patient had a fresh fracture of the right greater trochanter. (Hip bone) 2. Review of emails dated 7/7/21 - 8/9/21 indicated a family member notified the Greenwood office on 7/7/21, and stated the patient complained the aide struck the patient with a fist, causing a right hip fracture by the home health aide on 7/3/21. The patient was in significant pain and had been placed on Percocet. The agency failed to document any contact with the patient's physician to report the change in condition or verify findings from the scan. 3. On 8/10/21 at 11 AM, the family member was interviewed concerning the patient's injury. The family member stated they had contacted the physician on 7/3/21 due to the patient's significant pain but did not notify the agency until 7/7/2, due to waiting for radiology results. During an interview on 8/13/21 at 4 PM, the administrator was asked concerning the policy for contacting the physician when there is a change in patient condition. The administrator stated, "They didn't even tell us for a couple of weeks." When queried concerning the agency policy for contacting the physician, the administrator agreed that the physician had not been contacted until the case manager notified him on 7/13/21. The administrator had no further comment. 410 IAC 17-13-1(a)(2)	G0590		
G0942	Governing body CFR(s): 484.105(a) 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	G0942		

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G0942	Continued from page 10 services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the governing body failed to assume responsibility for the agency's overall management and operation, including review and update of all policies, and review, development, and execution of the agency's complaint process, including investigation, documentation, resolution, and communication. This deficiency had the potential to affect all165 active patients in one of one parent agency and 2 of 2 agency branches. Findings include: Review of an agency policy titled “Grievance Policy”, last revised 2/9/21, indicated “The patient has the right to voice grievances/complaints regarding treatment or care that is (or failed to be) furnished and lack of respect of property by anyone who is furnishing care/services on behalf of Adaptive. Adaptive will take action to prevent further potential violations, including retaliation, while the complaint is being investigated. [sic] Be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to Adaptive or an outside agency. The policy failed to include the patient's right to be free from injuries of unknown source, The policy also failed to indicate how a complaint/grievance is investigated, techniques used to investigate, including but not limited to, employee interview, complainant interview, record and policy review, police notification, and written employee statement; and failed to include instructions for documentation, investigation, resolution, communication, and expected reasonable timeframes for investigation, resolution, and communication. On 8/12/21 at 4 PM, the administrator/clinical manager was queried concerning the agency's responsibility when investigating a complaint, and what policy the administrator/clinical manager used to direct a complaint investigation. The administrator stated she thought that once the information was given to the corporate lawyers and corporate compliance individuals, the administrator was no longer responsible to follow	G0942		

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G0942	Continued from page 11 up on the complaint, as they expected "corporate" to do so. When queried as to whether the agency policy for abuse and neglect was up to date and provided the elements required for a complaint investigation, the administrator had no further information. 410 IAC 17-12-1(b)	G0942		
G0948	Responsible for all day-to-day operations CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the Administrator failed to ensure they were involved and provided oversight/management of a complaint allegation for abuse, including adequate investigation (including on-sight assessment, documentation, and communication with patient/family), and failed to ensure all patient information was contained in a confidential record and not left in emails for 1 (patient #4) of 1 record/ complaint reviewed of an allegation of abuse and failed to ensure complaints had a resolution for 4 (#4, 10, 11, 12) of 12 complaint investigations reviewed. This deficiency has the potential to affect all 165 patients receiving services from this agency. Findings include: 1. A review of the parent office grievance log indicated a complaint by a family member of patient #4, dated 7/7/21, that stated, “Client family called stating caregiver hurt client. [Name of Employee P] (an HHA) was the accused caregiver." The complaint resolution date was blank. Further review of the agency grievance log evidenced the patient family member reported the following timeline as documented by the administrator: “7/2/21 - [Name of employee P] told her that [name of patient #4] had a good day and [he/she] could see how much she ate. [Name of person E] stated [he/she] went to the kitchen and [name of employee P] left and as she was leaving [name of patient #4] showed [him/her] with [his/her] fist that she had hit [him/her] in [his/her] hip. [Name of person E] stated [he/she] would scream out in pain when moved that evening."	G0948		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K167	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAPTIVE NURSING AND HEALTHCARE	**6602 E 75TH STREET STE 230 , INDIANAPOLIS, Indiana, 46250**

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G0948	Continued from page 12 The grievance report continued with a second entry, dated 7/16/21, which indicated "Office brought [Name of employee P] in to get her statement. Denies turning or fully changing [Name of patient #4] and just had to change pad per family request. Only lifting to switch out maxi pad." The patient's family member stated the patient was experiencing unrelieved pain that required Percocet, a narcotic medication used to treat moderate to severe pain and had been diagnosed in the emergency department with a non-displaced fracture of the right greater trochanter. The clinical record failed to evidence that a registered nurse completed a comprehensive assessment of the patient upon notification of a change in condition, increased pain, and suspected abuse, and failed to evidence the agency notified the patient's physician. Further review indicated that follow up of the complaint was conducted via email between multiple individuals identified as "the team." The record failed to evidence the accused aide was queried concerning whether the patient was complaining of increased pain or had a change in condition on 7/2/21, failed to notify the patient's case manager of the change in condition, increased pain, and suspected abuse, failed to ensure the plan of care was accurate and complete, and failed to ensure documentation of the injury and complaint investigation was part of a confidential clinical record which followed HIPAA (Health Information Portability and Accountability Act) guidelines for sharing of necessary information only. The grievance report subsection titled "Resolution" indicated "pending". A section titled "Complaint (other than written) discussed with …" indicated the 2 available options of administrator and supervising nurse were blank. "Complaint reviewed by: Administrator/Supervising nurse" and "Patient [Name of patient #4] informed of resolution on _____ by _____" was blank. Sections indicating "Patient satisfied with the resolution", "If no satisfactory resolution, explain", and "Final resolution/date" were blank. A review of a document titled "Grievance Log, Greenwood", indicated a complaint about patient #4, dated 7/7/21 and signed by the administrator on 7/30/21. The complaint stated "Client family called stating caregiver hurt client. [Name of employee P (an HHA) was the accused caregiver." The complaint resolution date was blank. A Review of an email thread, provided by the	G0948		

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G0948	Continued from page 13 administrator on 8/13/21 at 4:45 PM, revealed the patient's family member notified the agency on 7/7/21 that the patient had a fresh, non-displaced fracture of the right greater trochanter. The patient's family member indicated the patient reported the home health aide hit the patient with her fist on 7/3/21. The patient was experiencing unrelieved pain, that required Percocet, a narcotic medication used to treat moderate to severe pain. The clinical record failed to evidence that a registered nurse completed a comprehensive assessment of the patient upon hearing of a change in condition, increased pain, and an injury of an unknown source and the clinical record failed to evidence that the patient's physician was notified. Further review indicated that follow up of the complaint occurred via email, between multiple individuals identified as "the team", however, the administrator/clinical manager failed to interview the patient or the patient's family member, who reported the suspected abuse, failed to notify the patient's case manager of the change in condition, increased pain, and injury of unknown source, failed to ensure the plan of care was accurate and complete, and failed to ensure documentation of the injury and complaint investigation was part of a confidential clinical record which followed HIPAA (Health Information Portability and Accountability Act) guidelines for sharing of necessary information only. A review of an email dated 7/13/21 at 4:31 PM from employee C indicated "Looping corporate in as we have additional information now." The email indicated the daughter of patient #4 called the office and stated, "[Name of employee P] had hurt [name of patient #4] by "throwing her around when she was turning [him/her] to change [him/her]." Person E and person I [a family member of patient #4] contacted the office and asked to speak with employee K, and RN (Registered Nurse). Employee R took the call, but when person I heard employee K was not in the building, the call was terminated. The email indicated that the visiting physician was contacted, and "they" came out and completed x-rays, which were inconclusive but did not show fractures. The email further stated that employee M called person E because patient #4 continued to cry out in pain. Employee P was removed from the patient's schedule and a new aide was provided. The email failed to include the resolution and whether the patient's family members were notified of the results.	G0948		

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G0948	Continued from page 14 During an interview on 8/12/21 at 4 PM, patient's family member stated they had not received any communication from the agency concerning resolution of the complaint and wondered if the aide was still providing services to other people. The family member also stated they were told by employee C, a registered nurse and branch manager, that "corporate was handling everything and it is out of our hands." The family member stated neither the patient nor any family members have been contacted by anyone from "corporate." During an interview on 8/13/21 at 3:30 PM, the administrator stated the complaint involving patient #4 had "been given to corporate." The administrator stated she thought that once the information was given to the corporate lawyers and corporate compliance individuals, the administrator was no longer responsible to follow up on the complaint, as they expected "corporate" to do so. The surveyor reviewed patient rights and complaint information from Condition of Participation 484.50, read from the State Operations Manual, and the administrator was queried concerning the agency's responsibility for investigating and resolving complaints. When queried as to whether any resolution was obtained related to the complaint of abuse to patient #4, the administrator stated, "We just called corporate yesterday to see where they were on this." When asked what the response to the call was, and where documentation concerning the call was found, the administrator stated there was no further information. The administrator was questioned concerning the existence of documentation for the complaint for patient #4 and stated there were emails showing communication between the agency and "corporate." The administrator was asked to provide printed copies of all emails related to patient #4. 2. A review of a complaint report dated 4/9/21, for patient #10, now discharged, revealed the resolution was blank, patient informed was blank, patient satisfied was blank, and the final resolution was blank. The agency failed to complete a full investigation which included documentation of the complaint resolution, when the patient was notified, and whether the patient was satisfied. 3. A review of a complaint report dated 5/21/21, for patient #11, now discharged, revealed the	G0948		

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	15K167	A. BUILDING B. WING	**08/16/2021**

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G0948	Continued from page 15 section for complaint reviewed by administrator/supervising nurse was blank. 4. A review of a complaint report dated 6/11/21, for patient #12 (discharged from Medicaid Prior Authorization services - a type of Medicaid coverage – on 7/9/21), revealed findings, resolution, patient informed of the resolution, patient satisfied, and final resolution sections were blank. 410 IAC 17-12-1(c)(1)	G0948		