STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012050	A. BUILDING: _____ B. WING _____	R 01/15/2021

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(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) COMPLETE DATE
{N 000}	Initial Comments This visit was a revisit for a Focused Infection Control and complaint survey of a home health agency conducted 8/19/2020 - 8/21/2020 and 8/24/2020 - 8/27/2020. Survey dates: 1/12/2021 - 1/15/2021 Facility Number: IN012050 04/14/21 Tag 9999 from 01/15/21 survey deleted.	{N 000}		
N 440	410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure the organization and lines of authority for the delegation of responsibility were identifiable. The findings include: Review of an agency policy revised 1/13/2020, titled "Location Management" stated, "... All branches of the Company are to be under the direction of an Administrator ... These appointments are made by the Governing Body...." Review of an agency document titled "Aveanna Healthcare Organizational Chart" indicated the	N 440		

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N 440	Continued From page 1 Location Director, Administrator and Alternate Administrator were located at the same position within the organizational structure. Review failed to evidence the alternate administrator reported to the administrator. During an interview at the entrance conference on 1/14/2021 at 10:30 a.m., the alternate administrator indicated the alternate administrator reported to the administrator.	N 440		
{N 444}	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. This RULE is not met as evidenced by: Based on record review and interview, the administrator failed to be responsible for all day-to-day operations of the agency. The findings include: Review of an agency policy revised 7/16/2020, titled "Scope of Services" stated, "... It is the policy of the Company to provide services to	{N 444}		

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{N 444}	Continued From page 2 patients/clients whose condition requires services that can by safely and effectively rendered in the patient's / client's / legal guardians home or other alternate care setting. ... The Company's scope of service includes provision and maintenance of the following: Nursing Services ... Rehab Therapy (Home and Clinic Based) Physical Therapy, Occupational Therapy, Speech Therapy ... Social Work ... Home Health Aide ...." Review of an agency policy revised 1/133/2020, titled "Location Management" stated, "... All branches of the Company are to be under the direction of an Administrator (also known as Location Director or Area Director) whose primary responsibility is organization and direction of day-to-day operations. A qualified Alternate Administrator is ... to assume responsibility for the operation of the location in the absence of an Administrator. ... The Location Director's responsibilities include: Organizing and directing ongoing functions ... Taking appropriate action to ensure compliance with Aveanna policies, accrediting body standards and applicable local, state, and federal law and regulation ... Employing qualified staff and ensuring utilization of staff with active/current licenses, credentials and personnel files ...." Review of an agency document revised 9/21/19, titled "Welcome to Aveanna Healthcare" stated, "... We strive to provide services that cover the healthcare needs of every patient, and our employees encompass a variety of clinical roles including Nurses, Home Health Aides, Certified Nursing Assistants, Personal Care Assistants, and Physical, Occupational, and Speech Therapists. ...." During an interview on 1/12/2021 at 9:55 a.m.,	{N 444}		

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{N 444}	Continued From page 3 the alternate administrator indicated the agency provided skilled nursing and home health aide services. The alternate administrator indicated no contracted services were provided by the agency. During an interview on 1/14/2021 at 1:50 p.m., when request made for the job description for employee F, licensed practical nurse, employee C, client services supervisor, indicated the alternate administrator did not have access to the electronic personnel record. During an interview on 1/14/2021 at 1:50 p.m., person A, area director, indicated only one person in the office can have access to the electronic personnel record and it was employee C who had access. During an interview on 1/14/2021 at 1:58 p.m., the alternate administrator indicated although she was the acting administrator in absence of the administrator while on medical leave, she was really the alternate administrator and did not oversee the personnel records and was the job of employee C. The alternate administrator indicated her job was more clinical and she did not have access to the electronic personnel record.	{N 444}		
{N 486}	410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to coordinate care with other	{N 486}		

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{N 486}	Continued From page 4 entities providing therapy services in 3 of 3 clinical records reviewed receiving skilled nursing services, in a total sample of 4 clinical records reviewed. (#1, #2, #3) The findings include: 1. Review of an agency policy revised 6/5/17, titled "Coordination of Care" stated, "... Regular communication will be maintained between patients and all providers of care in an effort to clarify the responsibilities of each party. These efforts may include, but are not limited to, telephone conferences, written notes, personal contact and other communication which are to be documented in the patient's medical record. It is the responsibility of location staff to identify and document the existence of other providers of care and services in order to assure appropriate coordination of care and services. ..." 2. Clinical record review for patient #1 on 1/13/2021, evidenced an untitled agency document, the alternate administrator identified as the skilled nurse visit note, dated and electronically signed by the registered nurse on 12/18/2020 stated, "... Started speech therapy lessons with speech therapist ...." Review failed to evidence coordination of care with the speech therapist. During an interview on 1/14/2021 at 12:28 p.m., the alternate administrator indicated there was no care coordination in the clinical record with the speech therapist. 3. Clinical record review for patient #2 on 1/13/2021, evidenced an untitled agency document, the alternate administrator identified as the comprehensive assessment, dated and	{N 486}		

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{N 486}	Continued From page 5 electronically signed by the registered nurse on 12/18/2020, which indicated the patient received speech and physical therapy from entity E. Review failed to evidence coordination of care between the home health agency and the agency providing speech and physical therapy. During an interview on 1/15/2021 at 10:36 a.m., the alternate administrator indicated there was no care coordination with the agency providing speech and physical therapy in the clinical record as she has not had the time. Review of an unsigned and undated document the alternate administrator provided on 1/15/2021 at 10:43 a.m. titled "Coordination of Care Documentation" indicated the patient received speech and physical therapy from entity E, but failed to evidence any coordination of care with entity E. During an interview on 1/15/2021 at 10:43 a.m., the alternate administrator indicated the care coordination form was faxed to entity E with a copy of the patient's plan of care, but did not speak with anyone at entity E to confirm the type and frequency of services provided to the patient. 4. Clinical record review for patient #3 on 1/14/2021, evidenced an untitled agency document, the alternate administrator identified as a skilled nurse visit note, dated 12/16/2020, and signed by the registered nurse, which indicated the patient was receiving physical therapy from entity F. Review failed to evidence care coordination between the home health agency and entity F. Request made on 1/14/2021 at 10:00 a.m. from entity F, related to the patient's physical therapy,	{N 486}		

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{N 486}	Continued From page 6 revealed person J at entity F had indicated the patient received physical therapy which began in June of 2019. During an interview on 1/15/2021 at 11:12 a.m., the alternate administrator indicated there was no care coordination with entity F in the clinical record. At 11:32 a.m., the alternate administrator indicated the type and frequency of services the patient received and the progress would be information the agency would want to obtain.	{N 486}		
N 504	410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure the patient / caregiver consented to in advance the changes in the frequency of services that were being furnished in 1 of 3 clinical records reviewed receiving skilled nursing services, in a total sample of 4 records reviewed. (#2) The findings include: Review of an agency document revised 7/30/19,	N 504		

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N 504	Continued From page 7 titled "Patient Rights and Responsibilities" stated, "... As a patient, member of a patient's family, or significant other, you have the right: ... Changes in any prior payment information should be given to the patient orally and in writing as soon as possible in advance of the next service provided. ... To expect continuity of care ... To be informed orally and in writing of any changes as soon as possible in advance of the next service provided...." Review of an agency document revised 11/6/17, titled "General Communication" stated, "... Any communications with patients, care-givers, families, staff, physicians, payers, case managers and other agencies or individuals involved in the patient's care shall be documented in the patient's medical record. ... Clinical record review of patient #2 on 1/13/2021, evidenced an agency document titled "Home Care Certification and Plan of Care" for certification period 12/23/2020 - 2/20/2021, signed and dated by the physician on 12/24/2020, which indicated the skilled nurse was to provide nursing services 8-16 hours a day, 5-7 days a week. Review failed to evidence skilled nursing services were provided at least 5 days a week during the weeks of 12/20/2020, 12/27/2020 and 1/3/2021 and for at least 8 hours a day on 12/23/2020 as directed in the plan of care. Review of an agency document titled "Patient Service Agreement" signed and dated by the patient's parent on 2/27/2020, indicated the patient was to receive 60 hours a week of skilled nursing services. Review failed to evidence the patient's parent consented in advance to the	N 504		

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N 504	Continued From page 8 changes in frequency of the skilled nursing services. During an interview on 1/15/2021 at 11:02 a.m., the alternate administrator indicated the skilled nursing services were not provided as ordered in the plan of care due to staffing issues. The alternate administrator indicated the skilled nurse had to adjust her schedule at the end of summer when school started. At 11:02 a.m., the alternate administrator indicated there was no documentation the patient's parent was notified of the change in skilled nursing frequency.	N 504		
{N 522}	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the plan of care was followed in 3 of 3 clinical records reviewed with skilled nursing services, in a total sample of 4 clinical records reviewed. (#1, #2, #3) The findings include: 1. Review of an agency policy revised 9/19/19, titled "Physician Orders" stated, "... Care and services will be provided in accordance with physician's (or other authorized individual's) orders, as required by law and regulation. ... A complete, individualize Plan of Care/Treatment will be developed for all patients receiving clinical	{N 522}		

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{N 522}	Continued From page 9 services according to applicable law and state regulations. The initial Plan of Care/Treatment is developed in conjunction with the physician/prescriber, patient/family and the Company's health care professional as part of the admission process...." 2. Review of an agency policy revised 5/19/20, titled "Cough Assist Machine" stated, "... Documentation ... Date and time equipment is used ... Response/tolerance to therapy ... Cough effort ... Duration of treatment ... Quality of secretions ... Suctioning, if appropriate ...." 3. Clinical record review for patient #1 on 1/13/2021, evidenced agency documents titled "Home Health Certification and Plan of Care" for certification period 11/6/2020 - 1/4/2021 and 1/5/2021 - 3/5/2021, which indicated the skilled nurse was to provide intermittent water flushes via the g-tube (a surgically inserted tube into the stomach through the abdomen to provide nutrition, fluid and medication) totaling 150 milliliters (ml) from 10 p.m. to 7 a.m. The plan of care also indicated the skilled nurse was to insert a straight urinary catheter (a tube inserted into the bladder through the urethra to drain urine from the body) every 3-4 hours during the day and insert a urinary foley catheter (a tube inserted into the bladder and held in place with a small inflated balloon to drain urine from the body into a collection bag) nightly at 8 p.m. and connect to gravity bag until 8 a.m.. Review of an untitled agency document, the alternate administrator identified as a skilled nurse visit note, electronically signed and dated by the registered nurse on 12/22/2020, evidenced the nurse provided 170 ml of water flushes via the g-tube between 11:30 p.m. on 12/21/2020 to 5:30	{N 522}		

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{N 522}	Continued From page 10 a.m. on 12/22/2020. The review failed to evidence the nurse provided a total of 150 ml of water flushes via the g-tube as directed in the plan of care. During an interview on 1/14/2021 at 12:42 p.m., the alternate administrator indicated the plan of care directed the skilled nurse to provide 150 ml of water flushes via the patient's g-tube. Review of untitled agency documents the alternate administrator identified as skilled nurse visit notes evidenced the skilled nurse removed the foley catheter at 5:30 a.m. on 12/16/2020, 6:30 a.m. on 12/17/2020, 5:30 a.m. on 12/18/2020, 5:30 a.m. on 12/21/2020, 5:30 a.m. on 12/22/2020, 5:30 a.m. on 12/23/2020, 5:30 a.m. on 12/24/2020, 5:30 a.m. on 12/29/2020, 5:30 a.m. on 12/31/2020, 5:30 a.m. on 1/1/2021, 5:30 a.m. on 1/4/2021, 5:30 a.m. on 1/5/2021, 5:30 a.m. on 1/6/2021, 5:30 a.m. on 1/7/2021, 5:30 a.m. on 1/8/2021, 6:15 a.m. on 1/9/2021, 5:30 a.m. on 1/12/2021 and 5:30 a.m. on 1/15/2021. Record review failed to evidence the skilled nurse followed the plan of care to remove the foley catheter at 8 a.m. as directed. Review of untitled agency documents, the alternate administrator identified as skilled nurse visit notes, evidenced employee D, registered nurse, removed the patient's foley catheter on 12/17/2020 at 6:30 a.m. and failed to evidence any urinary catheterization after the removal of the foley catheter prior to the nurse's departure at 8:16 a.m.. Employee E arrived at 9:00 a.m. and failed to evidence the skilled nurse performed a urinary straight catheterization prior to 11:15 a.m. on 12/17/2020. Record review failed to evidence the skilled nurse performed urinary straight catheterization every 3-4 hours as directed in the	{N 522}		

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{N 522}	Continued From page 11 plan of care. During an interview on 1/14/2021 at 12:12 p.m., the alternate administrator indicated the skilled nurse was to remove the foley catheter at 8 a.m. per the plan of care. At 12:25 p.m., the alternate administrator indicated any care reported as performed by the caregiver should be documented by the agency staff. During an interview on 1/14/2021 at 12:25 p.m., employee B, licensed practical nurse, indicated the skilled nurse did not follow the plan of care to catheterize the patient every 3-4 hours. Review of the agency document titled "Home Care Certification and Plan of Care" for certification period 11/6/2020 - 1/4/2020, signed and dated by the physician on 11/23/2020, indicated the skilled nurse was to provide nursing services 12-24 hours a day, 5-7 days a week. The patient's medication included, but was not limited to, 3% Sodium Chloride (a medication used to produce sputum to increase lung function) 1 vial inhaled twice daily. Review of untitled agency documents, the alternate administrator identified as skilled nursing visit notes, evidenced the skilled nurse provided nursing care on 12/16/2020, 12/17/2020, 12/18/2020, 12/19/2020, 12/20/2020, 12/21/2020, 12/22/2020, 12/23/2020, 12/24/2020, 12/28/2020, 12/29/2020, 12/30/2020, 12/31/2020, 1/1/2021 and 1/2/2021. Review of agency documents titled "Medication Administration Record / Medication Profile" dated for the weeks 12/13/2020 - 12/19/2020, 12/20/2020 - 12/26/2020 and 12/27/2020 - 1/2/2021, failed to evidence the skilled nurse administered 3% Sodium Chloride as directed in the plan of care.	{N 522}		

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{N 522}	Continued From page 12 During an interview on 1/14/2021 12:56 p.m., the alternate administrator indicated she was unsure why the medication administration record indicated the 3% Sodium Chloride was marked as discontinued and there was not a physician order for the discontinuation of the medication. The alternate administrator indicated the skilled nurse was to initial the medication administration record if the medication was administered. 4. Clinical record review for patient #2 on 1/13/2021, evidenced an agency document titled "Home Care Certification and Plan of Care" for certification period 12/23/2020 - 2/20/2021, signed and dated by the physician on 12/24/2020, which indicated the skilled nurse was to provide nursing services 8-16 hours a day, 5-7 days a week. The skilled nurse was to administer cough assist treatments (a non-invasive treatment to clear the airway when unable to cough or clear airway secretions effectively) for 3 cycles of 5 breaths every 6 hours and as needed. Review of untitled agency documents, the alternate administrator identified as skilled nurse visit notes, dated and electronically signed by the skilled nurse on 12/30/2020, 1/4/2021, 1/8/2021 and 1/11/2021, failed to evidence the skilled nurse provided cough assist treatments as ordered in the plan of care. During an interview on 1/15/2021 at 10:50 a.m., the alternate administrator indicated the skilled nurse notes do not state if the skilled nurse provided the cough assist treatments. The alternate administrator indicated the skilled nurse should document the cough assist treatment was performed per orders and indicate the number of breaths provided and at what setting.	{N 522}		

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(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) COMPLETE DATE
{N 522}	Continued From page 13 Review failed to evidence skilled nursing services were provided at least 5 days a week during the weeks of 12/20/2020, 12/27/2020 and 1/3/2021, and for at least 8 hours a day on 12/23/2020, as directed in the plan of care. During an interview on 1/15/2021 at 11:02 a.m., the alternate administrator indicated the skilled nursing services were not provided as ordered in the plan of care due to staffing issues. The alternate administrator indicated the skilled nurse had to adjust her schedule at the end of summer when school started. 5. Clinical record review for patient #3 on 1/14/2021, evidenced an agency document titled "Home Care Certification and Plan of Care" for certification period 11/5/2020 - 1/3/2021, signed and dated by the physician on 11/20/2020, which indicated the patient was to receive skilled nursing services 8-10 hours a day, 3-5 days a week. Review failed to evidence the agency provided skilled nursing services from 12/18/2020 - 12/27/2020, as ordered in the plan of care. During an interview on 1/15/2020 at 11:38 a.m., employee B, licensed practical nurse, indicated the agency should have obtained a verbal order to hold services that were not being provided as ordered. During an interview on 1/15/2020 at 11:45 a.m., employee C, client services supervisor, indicated skilled nursing services were not provided from 12/18/2020 to 12/27/2020, because the nurse took time off.	{N 522}		

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	012050	A. BUILDING: _____ B. WING _____	R 01/15/2021

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{N 524}	Continued From page 14	{N 524}		
{N 524}	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: (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. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the plan of care was individualized to contain medical supplies, patient-specific interventions and goals and medications in 4 of 4 clinical records reviewed. (#1, #2, #3, #4) The findings include: 1. Review of an agency policy revised 9/19/19, titled "Physician Orders" stated, "... A complete,	{N 524}		

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{N 524}	Continued From page 15 individualized Plan of Care/Treatment will be developed for all patients receiving clinical services according to applicable law and state regulations. The initial Plan of Care/Treatment is developed in conjunction with the physician/prescriber, patient/family and the Company's health care professional as part of the admission process. ... The Plan of Care/Treatment must include the following as applicable: ... Primary and secondary diagnosis ... A description of any Treatments, procedures and services and/or specific therapy to be performed. ... Medications (including over the counter) and treatments to be administered ... Equipment and related supplies ... Achievable, measurable, time-related long and short term goals and objectives that are related to the functioning of the recipient ... Relevant parameters to notify the MD [medical doctor] of changes in condition...." 2. Clinical record review for patient #1 on 1/13/2021, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/5/2021 - 3/5/2021 which indicated the patient was 7 years old. The document indicated patient was to receive skilled nursing services 12-24 hours a day, 5-7 days a week, and the physician was to be notified if the heart rate below 60 beats per minute or above 190 beats per minute and if the respiration rate was below 19 breaths per minute or above 50 breaths per minute. The document further identified the skilled nursing interventions included, but were not limited to, straight catheterization (inserting a tube into the bladder through the urethra to drain the urine) every 3-4 hours during the day while patient is awake and inserting a foley catheter (a tube inserted into the bladder through the urethra to drain urine out of the body into a collection bag) from 8 p.m. to 8	{N 524}		

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{N 524}	Continued From page 16 a.m. every night. The skilled nursing interventions also included administering the patient's nutrition and medications via gastrostomy (a surgically inserted tube into the stomach through the abdomen to deliver nutrition, fluids and medications) and cleaning the gastrostomy site twice daily. The plan of care failed to evidence patient-specific goals related to the urinary catheterization and gastrostomy feedings and care. Review of an untitled agency document the alternate administrator identified as the comprehensive assessment dated and electronically signed by the registered nurse on 1/4/2021 indicated the range for pulse was 50-120 beats per minute and the range for respiration was 12-28 breaths per minute. Review of a reference document titled "Pediatric Vital Signs Normal Ranges" website https://medicine.uiowa.edu/iowaprotocols/pediatric-vital-signs-normal-ranges indicated the normal range for the heart rate for a 7 year old was 65-120 beats per minute and the normal range for the respiratory rate for a 7 year old was 15-30 breaths per minute. Review failed to evidence the clinical record failed to evidence the heart rate and respiration parameters were individualized to meet the needs of the patient's age. During an interview on 1/14/2021 at 11:52 a.m., the alternate administrator indicated the agency did not have any patient-specific directions from the patient's physician related to the pulse and respiration parameters. The alternate administrator indicated the patient-specific goals would include the patency of the catheter and	{N 524}		

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{N 524}	Continued From page 17 gastrostomy, balanced intake and output and abdomen free of distention. Request made on 1/14/2021 at 2:25 p.m. from the primary's physician office related to the pulse and respiration parameters revealed person B, nurse at the primary physician's office, indicated the primary physician did not determine the parameters for pulse or respiration and there was no patient-specific parameters in the patient's record at the physician's office. Review of an untitled agency document the alternate administrator identified as a skilled nursing visit note dated and electronically signed by the registered nurse on 1/8/2021 evidenced the patient was wearing a splint on the left hand. The plan of care failed to evidence the patient's supplies and medical equipment included the hand splint. During an interview on 1/14/2021 at 12:07 p.m., the alternate administrator indicated the plan of care did not contain the left hand splint but should have been included in the patient's medical supplies in the plan of care. 3. Clinical record review for patient #2 on 1/13/2021 evidenced an agency document titled "Home Care Certification and Plan of Care" for certification period 12/23/2020 - 2/20/2021 which indicated the patient was to receive CPT (chest physiotherapy; an airway clearing technique to drain the lungs utilizing a vest which performs pulses and squeezes) vest treatments every 6 hours and prn (as needed). Review also evidenced the skilled nurse was to provide bolus gastrostomy tube feedings 4 times daily. The plan of care failed to indicate the prn indications for the CPT vest treatment and patient-specific times of	{N 524}		

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{N 524}	Continued From page 18 the gastrostomy tube feedings. During an interview on 1/13/2021 at 3:15 p.m., the alternate administrator indicated the gastrostomy tube feedings should be spaced apart and indicated the skilled nurse in the home indicated the patient received tube feedings at 9 a.m., 12 p.m., 3 p.m. and 6 p.m. daily and should be included in the plan of care. During an interview on 1/15/2021 at 10:49 a.m., the alternate administrator indicated the prn indications for the CPT vest treatment were for congestion and thickened secretions and should be included in the plan of care. 4. Clinical record review for patient #3 on 1/14/2021 evidenced an agency document titled "Home Care Certification and Plan of Care" for certification period 11/5/2020 - 1/3/2021 signed and dated by the physician on 11/20/2020 which indicated the skilled nurse was to place the patient on biPAP (a treatment that uses mild air pressure to keep the airway open) via a nasal mask. The document indicated the patient's medication included, but was not limited to, Nystatin cream (antifungal medication), which was to applied to a rash as needed three times daily. Review failed to evidence the plan of care was individualized to include when the skilled nurse was to provide the BiPAP treatment and for how long. Review failed to evidence the plan of care was individualized to include where the rash on the body was located where the Nystatin cream was to be applied. During an interview on 1/15/2021 at 11:33 a.m., the alternate administrator indicated the plan of care did not include when the BiPAP was to be used and when it should be removed. At 11:45	{N 524}		

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{N 524}	Continued From page 19 a.m., the alternate administrator indicated she was unsure where the Nystatin cream was to be applied. Review of an agency document titled "Home Care Certification and Plan of Care" for certification period 1/4/2021 - 3/4/2021 signed and dated by the provider on 12/30/2020 indicated the skilled nurse was to provide gastrostomy care and provide gastrostomy tube feedings and medications. Review failed to evidence the plan of care was individualized to include the orders for the inflation of the gastrostomy tube. During an interview on 1/15/2021 at 11:50 a.m., the alternate administrator indicated the plan of care did not specify the gastrostomy tube inflation orders and she needed to obtain an order to determine the amount of inflation and whether it was to be inflated with air or water. During an interview on 1/15/2021 at 11:52 a.m., employee B, licensed practical nurse, indicated the orders for the inflation of the gastrostomy tube should be included in the plan of care. 5. Clinical record review for patient #4 on 1/12/2021 evidenced a document from the patient's primary physician titled "Progress Notes" dated 8/18/2020 which indicated the patient was to take an albuterol inhaler (to treat wheezing or shortness of breath) as needed. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 12/5/2020 - 2/2/2021 failed to evidence the patient's medications included albuterol. During an interview on 1/13/2021 at 11:02 a.m.,	{N 524}		

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{N 524}	Continued From page 20 the patient's legal guardian indicated the patient does take the albuterol inhaler as needed for asthma. During an interview on 1/15/2021 at 12:21 p.m., the alternate administrator indicated all of the patient's medications should be included on the plan of care.	{N 524}		
{N 527}	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to promptly alert the physician to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and that the plan of care should be altered in 1 of 3 records receiving skilled nursing services (#1) and in 1 of 1 record receiving home health aide services (#4) in a total sample of 4 clinical records reviewed. The findings include: 1. Review of an agency policy revised 9/19/19 titled "Physician Orders" stated, "... The physician must be promptly alerted to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or the POC [plan of care] should be altered. ..."	{N 527}		

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{N 527}	Continued From page 21 2. Clinical record review for patient #1 on 1/13/2021 evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 11/6/2020 - 1/4/2021 signed and dated by physician D on 11/23/2020 which indicated the patient's tracheostomy (a surgically created hole in the neck and into the airway to assist with breathing) cuff should be inflated between 2.3 ml (milliliters) to 2.7 ml while the patient is asleep. Review of an agency document titled "Physician Order Form" dated 12/17/2020 signed by physician C indicated the patient's tracheostomy cuff was to be inflated up to 3 ml at night as as needed for comfort. Record review failed to evidence the physician responsible for the plan of care was notified of the change in tracheostomy cuff inflation orders from physician C prior to 1/6/2021 when the plan of care for certification period beginning 1/5/2021 was signed which was a time period greater than 2 weeks. During an interview on 1/14/2021 at 12:49 p.m., the alternate administrator indicated the physician was not notified and changes should be reported the same day. 3. Clinical record review for patient #4 on 1/12/2021 evidenced a document from the patient's primary physician titled "Progress Notes" dated 8/18/2020 which indicated the patient was to continue her medication including, but not limited to, Lamictal (a medication to treat seizures) daily and albuterol inhaler (to treat wheezing or shortness of breath) as needed. Review of an agency document titled "Home Health Certification and Plan of Care" for	{N 527}		

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{N 527}	Continued From page 22 certification period 12/3/2020 - 2/2/2021 signed and dated by the physician on 1/7/2021 indicated the patient was 14 years old and diagnoses included, but were not limited to, epilepsy (a disorder that causes seizures), post traumatic seizures, cerebral palsy and attention deficit hyperactivity disorder. Review evidenced the patient was to receive home health aide services 5-7 days a week and the home health aide was to notify the supervising nurse for all changes in the patient's status. The patient's medications included, but were not limited to, Guanfacine (a medication to treat Attention Deficit Hyperactivity Disorder) daily. The plan of care failed to evidence the patient's medication included Lamictal. During an interview at the patient's home on 1/13/2021 at 8:08 a.m., the patient's legal guardian indicated she could not afford the patient's medications not covered by the insurance so the patient has gone without those medications. At 11:02 a.m., the legal guardian indicated the physician ordered a new seizure medication, which name she could not recall, so she has not picked up the medication at the pharmacy. The legal guardian indicated the patient has not been taking Guanfacine because she could not afford the medication as it was not covered by the patient's insurance. Review failed to evidence the agency communicated with the physician the patient was not taking Guanfacine and Lamictal as prescribed or requested a medication change that would be covered by the patient's insurance. During an interview on 1/15/2021 at 11:59 a.m., the alternate administrator indicated she was aware the patient's legal guardian could not afford	{N 527}		

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{N 527}	Continued From page 23 the Lamictal. At 12:21 p.m., the alternate administrator indicated the patient's legal guardian was also the home health aide providing services to the patient, and the home health aide should have notified the supervising nurse the patient was not taking the Guanfacine and Lamictal. At 12:26 p.m., the alternate administrator indicated the physician had not been notified the patient was not taking Lamictal and Guanfacine.	{N 527}		
{N 537}	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: This RULE is not met as evidenced by: Based on record review and interview, the registered nurse failed to provide services ordered by the physician as indicated in the plan of care in 2 of 3 records reviewed receiving skilled nursing services from a registered nurse in a total sample of 4 clinical records reviewed. (#1, #2) The findings include: 1. Review of an agency policy revised 9/19/19 titled "Physician Orders" stated, "... Care and services will be provided in accordance with physician's (or other authorized individual's) orders, as required by law and regulation. 2. Review of an agency policy revised 9/21/2020 titled "Skilled Professional Services" stated, "... Skilled professional services are provided by a	{N 537}		

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{N 537}	Continued From page 24 Registered Nurse or a Licensed Practical Nurse/Licensed Vocational Nurse under the supervision of a Registered Nurse ... and in accordance with a medically approved Plan of Care/Treatment ... All skilled professionals are to participate in all aspects of care including: ... Providing services that are ordered by the physician as indicated in the plan of care ...." 3. Review of an agency policy revised 5/19/20 titled "Cough Assist Machine" stated, "... Documentation ... Date and time equipment is used ... Response/tolerance to therapy ... Cough effort ... Duration of treatment ... Quality of secretions ... Suctioning, if appropriate ...." 4. Clinical record review for patient #1 on 1/13/2021 evidenced agency documents titled "Home Health Certification and Plan of Care" for certification period 11/6/2020 - 1/4/2021 and 1/5/2021 - 3/5/2021 which indicated the skilled nurse was to provide intermittent water flushes via the g-tube (a surgically inserted tube into the stomach through the abdomen to provide nutrition, fluid and medication) totaling 150 milliliters (ml) from 10 p.m. to 7 a.m. The plan of care also indicated the skilled nurse was to insert a urinary foley catheter (a tube inserted into the bladder and held in place with a small inflated balloon to drain urine from the body into a collection bag) nightly at 8 p.m. and connect to gravity bag until 8 a.m.. Review of an untitled agency document the alternate administrator identified as a skilled nurse visit note electronically signed and dated by the registered nurse on 12/22/2020 evidenced the nurse provided 170 ml of water flushes via the g-tube between 11:30 p.m. on 12/21/2020 to 5:30 a.m. on 12/22/2020. The review failed to	{N 537}		

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{N 537}	Continued From page 25 evidence the registered nurse provided a total of 150 ml of water flushes via the g-tube as directed in the plan of care. During an interview on 1/14/2021 at 12:42 p.m., the alternate administrator indicated the plan of care directed the skilled nurse to provide 150 ml of water flushes via the patient's g-tube. Review of untitled agency documents the alternate administrator identified as skilled nurse visit notes evidenced the registered nurse removed the foley catheter at 5:30 a.m. on 12/16/2020, 6:30 a.m. on 12/17/2020, 5:30 a.m. on 12/18/2020, 5:30 a.m. on 12/21/2020, 5:30 a.m. on 12/22/2020, 5:30 a.m. on 12/23/2020, 5:30 a.m. on 12/24/2020, 5:30 a.m. on 12/29/2020, 5:30 a.m. on 12/31/2020, 5:30 a.m. on 1/1/2021, 5:30 a.m. on 1/4/2021, 5:30 a.m. on 1/5/2021, 5:30 a.m. on 1/6/2021, 5:30 a.m. on 1/7/2021, 5:30 a.m. on 1/8/2021, 5:30 a.m. on 1/12/2021 and 5:30 a.m. on 1/15/2021. Record review failed to evidence the skilled nurse followed the plan of care to remove the foley catheter at 8 a.m. as directed. During an interview on 1/14/2021 at 12:12 p.m., the alternate administrator indicated the skilled nurse was to remove the foley catheter at 8 a.m. per the plan of care. Review of the agency document titled "Home Care Certification and Plan of Care" for certification period 11/6/2020 - 1/4/2020 signed and dated by the physician on 11/23/2020 indicated the skilled nurse was to provide nursing services 12-24 hours a day, 5-7 days a week. The patient's medication included, but was not limited to, 3% Sodium Chloride (a medication used to produce sputum to increase lung	{N 537}		

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AVEANNA HEALTHCARE	2600 ROOSEVELT RD, SUITE 200-1 VALPARAISO, IN 46383

(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) COMPLETE DATE
{N 537}	Continued From page 26 function) 1 vial inhaled twice daily. Review of untitled agency documents the alternate administrator identified as skilled nursing visit notes evidenced the registered nurse provided nursing care on 12/16/2020, 12/17/2020, 12/18/2020, 12/20/2020, 12/21/2020, 12/22/2020, 12/23/2020, 12/28/2020, 12/30/2020 and 12/31/2020. Review of agency documents titled "Medication Administration Record / Medication Profile" dated for the weeks 12/13/2020 - 12/19/2020, 12/20/2020 - 12/26/2020 and 12/27/2020 - 1/2/2021 failed to evidence the registered nurse administered 3% Sodium Chloride as directed in the plan of care. During an interview on 1/14/2021 12:56 p.m., the alternate administrator indicated she was unsure why the medication administration record indicated the 3% Sodium Chloride was marked as discontinued and there was not a physician order for the discontinuation of the medication. The alternate administrator indicated the skilled nurse is to initial the medication administration record if the medication was administered. 5. Clinical record review for patient #2 on 1/13/2021 evidenced an agency document titled "Home Care Certification and Plan of Care" for certification period 12/23/2020 - 2/20/2021 signed and dated by the physician on 12/24/2020 which indicated the skilled nurse was to provide nursing services 8-16 hours a day, 5-7 days a week. The skilled nurse was to administer cough assist treatments (a non-invasive treatment to clear the airway when unable to cough or clear airway secretions effectively) for 3 cycles of 5 breaths every 6 hours and as needed. Review of untitled agency documents the	{N 537}		

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{N 537}	Continued From page 27 alternate administrator identified as skilled nurse visit notes dated and electronically signed by the registered nurse on 12/30/2020, 1/4/2021, 1/8/2021 and 1/11/2021 failed to evidence the skilled nurse provided cough assist treatments as ordered in the plan of care. During an interview on 1/15/2021 at 10:50 a.m., the alternate administrator indicated the skilled nurse notes do not state if the skilled nurse provided the cough assist treatments. The alternate administrator indicated the skilled nurse should document the cough assist treatment was performed per orders and indicate the number of breaths provided and at what setting.	{N 537}		
{N 542}	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. This RULE is not met as evidenced by: Based on record review and interview, the registered nurse failed to revise the plan of care to reflect current health status and nursing needs in 2 of 3 records reviewed with skilled nursing services in a total sample of 4 clinical records reviewed. (#1, #2) The findings include: 1. Review of an agency policy revised 9/19/19 titled "Physician Orders" stated, "... A complete, individualized Plan of Care/Treatment will be developed for all patients receiving clinical	{N 542}		

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{N 542}	Continued From page 28 services according to applicable law and state regulations. ... The Plan of Care/Treatment must be reviewed and revised as frequently as the patient's condition or needs require ...." 2. Clinical record review for patient #1 on 1/13/2021 evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 11/6/2020 - 1/4/2021 signed and dated by physician D on 11/23/2020 which indicated the patient's tracheostomy (a surgically created hole in the neck and into the airway to assist with breathing) cuff should be inflated between 2.3 ml (milliliters) to 2.7 ml while the patient is asleep. Review of an agency document titled "Physician Order Form" dated 12/17/2020 signed by physician C indicated the patient's tracheostomy cuff was to be inflated up to 3 ml at night as as needed for comfort. Review of an agency document titled "Physician Order Form" dated 12/21/2020 and signed by the physician indicated gauze to be used at the tracheostomy site and changed as needed. Record review failed to evidence the plan of care was revised to reflect the order for the gauze at the tracheostomy site and the change in the tracheostomy cuff. During an interview on 1/14/2021 at 12:51 p.m., the alternate administrator indicated the plan of care for certification period ending 1/4/2021 was not revised. 3. Clinical record review for patient #2 on 1/13/2021 evidenced an agency document titled "Home Health Certification and Plan of Care" for	{N 542}		

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{N 542}	Continued From page 29 certification period 12/23/20020 - 2/20/2021 indicated the skilled nurse was to maintain the Mickey button (a type of gastrostomy tube which is surgically inserted into the stomach through the abdomen for the administration of nutrition, fluid and medication) 12 Fr (french gauge system used to measure the size of a gastrostomy tubes), 1.5 cm (centimeter). Review of an agency document titled "Physician Order Form" dated 1/8/2021 and signed by the physician indicated the Mickey button size was changed to 12 Fr 1.7 cm. Record review failed to evidence the plan of care was revised to reflect the change in the Mickey button size. During an interview on 1/15/2021 at 10:35 a.m., the alternate administrator indicated the plan of care was not revised to reflect the change in the Mickey button size.	{N 542}		
N 558	410 IAC 17-14-1(a)(2)(F) Scope of Services Rule 14 Sec. 1(a) (2)(F) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (F) Accept and carry out physician, dentist, chiropractor, podiatrist, or optometrist orders (oral and written). This RULE is not met as evidenced by: Based on record review and interview, the licensed practical nurse failed to provide services ordered by the physician as indicated in the plan of care in 1 of 1 record reviewed receiving skilled nursing services from a licensed practical nurse in a total sample of 4 clinical records reviewed.	N 558		

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N 558	Continued From page 30 (#1) The findings include: Review of an agency policy revised 9/19/19 titled "Physician Orders" stated, "... Care and services will be provided in accordance with physician's (or other authorized individual's) orders, as required by law and regulation. Review of an agency policy revised 9/21/2020 titled "Skilled Professional Services" stated, "... Skilled professional services are provided by a Registered Nurse or a Licensed Practical Nurse/Licensed Vocational Nurse under the supervision of a Registered Nurse ... and in accordance with a medically approved Plan of Care/Treatment ... All skilled professionals are to participate in all aspects of care including: ... Providing services that are ordered by the physician as indicated in the plan of care ...." Clinical record review for patient #1 on 1/13/2021 evidenced agency documents titled "Home Health Certification and Plan of Care" for certification period 11/6/2020 - 1/4/2021 and 1/5/2021 - 3/5/2021 which indicated the skilled nurse was to insert a straight urinary catheter (a tube inserted into the bladder through the urethra to drain urine from the body) every 3-4 hours during the day and insert a urinary foley catheter (a tube inserted into the bladder and held in place with a small inflated balloon to drain urine from the body into a collection bag) nightly at 8 p.m. and connect to gravity bag until 8 a.m.. Review of untitled agency documents the alternate administrator identified as skilled nurse visit notes evidenced the licensed nurse removed the foley catheter at 6:15 a.m. on 1/9/2021.	N 558		

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N 558	Continued From page 31 Record review failed to evidence the licensed nurse followed the plan of care to remove the foley catheter at 8 a.m. as directed. Review of untitled agency documents the alternate administrator identified as skilled nurse visit notes evidenced employee D, registered nurse, removed the patient's foley catheter on 12/17/2020 at 6:30 a.m. and failed to evidence any urinary catheterization after the removal of the foley catheter prior to the nurse's departure at 8:16 a.m.. Employee E, licensed practical nurse, arrived at 9:00 a.m. and failed to evidence the licensed practical nurse performed a urinary straight catheterization prior to 11:15 a.m. on 12/17/2020. Record review failed to evidence the skilled nurse performed urinary straight catheterization every 3-4 hours as directed in the plan of care. During an interview on 1/14/2021 at 12:12 p.m., the alternate administrator indicated the skilled nurse was to remove the foley catheter at 8 a.m. per the plan of care. During an interview on 1/14/2021 at 12:25 p.m., employee B, licensed practical nurse, indicated the skilled nurse did not follow the plan of care to catheterize the patient every 3-4 hours. Review of the agency document titled "Home Care Certification and Plan of Care" for certification period 11/6/2020 - 1/4/2020 signed and dated by the physician on 11/23/2020 indicated the skilled nurse was to provide nursing services 12-24 hours a day, 5-7 days a week. The patient's medication included, but was not limited to, 3% Sodium Chloride (a medication used to produce sputum to increase lung function) 1 vial inhaled twice daily.	N 558		

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N 558	Continued From page 32 Review of untitled agency documents the alternate administrator identified as skilled nursing visit notes evidenced the licensed practical nurse provided nursing care on 12/16/2020, 12/18/2020, 12/19/2020, 12/21/2020, 12/22/2020, 12/23/2020, 12/24/2020, 12/29/2020, 12/30/2020, 12/31/2020, 1/1/2021 and 1/2/2021. Review of agency documents titled "Medication Administration Record / Medication Profile" dated for the weeks 12/13/2020 - 12/19/2020, 12/20/2020 - 12/26/2020 and 12/27/2020 - 1/2/2021 failed to evidence the licensed practical nurse administered 3% Sodium Chloride as directed in the plan of care. During an interview on 1/14/2021 12:56 p.m., the alternate administrator indicated she was unsure why the medication administration record indicated the 3% Sodium Chloride was marked as discontinued and there was not a physician order for the discontinuation of the medication. The alternate administrator indicated the skilled nurse is to initial the medication administration record if the medication was administered.	N 558		
{N 608}	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall	{N 608}		

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{N 608}	Continued From page 33 be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure the clinical record included all clinical notes in 1 of 3 records reviewed with skilled nursing services in a total sample of 4 clinical records reviewed. (#2) The findings include: Review of an agency policy revised 11/3/2020 titled "Documentation Standards" stated, "... All documentation related to care is to become part of the permanent record. ... Documentation is via paper or electronic. ... Clinical paper progress and other associated paper notes are to be written at the time the service is rendered and incorporated into the clinical record ... per state regulation. All electronic documentation is captured and submitted at the point of care...." Clinical record review for patient #2 on 1/13/2021 evidenced an untitled agency document the alternate administrator identified as the comprehensive assessment dated and electronically signed by the registered nurse on 12/18/2020 which indicated the patient received speech and physical therapy from entity E. Review failed to evidence coordination of care with the agency providing speech and physical therapy. During an interview on 1/15/2021 at 10:36 a.m.,	{N 608}		

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{N 608}	Continued From page 34 the alternate administrator indicated there was not care coordination in the clinical record with the agency providing speech and physical therapy in the clinical record as she has not had the time. Review conducted of an unsigned and undated document the alternate administrator provided on 1/15/2021 at 10:43 a.m. titled "Coordination of Care Documentation". During an interview on 1/15/2021 at 10:43 a.m., the alternate administrator indicated the care coordination document was found in her folder and not in the patient's clinical record. Review failed to evidence the patient's medications were reviewed since 10/23/2020. When queried on 1/13/2021 at 11:55 a.m. regarding when the patient's medications were last reviewed, the alternate administrator verified the last medication review was completed on 10/23/2020 when the medication profile was signed and dated by the registered nurse. Review of an agency document the alternate administrator provided on 1/13/2021 at 12:05 p.m. titled "Medication Profile" signed by the alternate administrator and dated 12/18/2020. During an interview on 1/13/2021 at 12:05 p.m., the alternate administrator indicated she located the medication profile in a folder she takes to the patient's home and indicated a copy should have been entered into the patient's clinical record. During an interview on 1/14/2021 at 12:35 p.m., the alternate administrator indicated the clinical record documentation was to be maintained in the hard chart in the office or in the electronic	{N 608}		

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{N 608}	Continued From page 35 health record.	{N 608}		
{N 610}	410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure all entries in the clinical record were accurate, complete and appropriately authenticated to include a signature and title, dated and timed in 3 of 3 records reviewed with skilled nursing services in a total sample of 4 clinical records reviewed. (#1, #2, #3) The findings include: 1. Review of an agency policy revised 11/3/2020 titled "Documentation Standards" stated, "... Any person who makes entries will complete each entry by recording the following: ... Date and time of entry. ... First and last name. Discipline and Title. Standards for documentation are listed as follows, but not limited to: ... All entries are: legible, complete, organized, current, meaningful and succinct. ... Documentation must be detailed, accurate, reflective of care/services provided ...." 2. Review of an agency policy revised 6/14/17 titled "Progress Summaries" stated, "... The Company provides a documented progress summary to physicians ... as per law and regulation ... Summary reports as needed/requested are sent to the primary	{N 610}		

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{N 610}	Continued From page 36 physician and are to include but not necessarily limited to: Changes in condition ... Outcome of Treatment ... Response to care ...." 3. Clinical record review for patient #1 on 1/13/2021 evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 11/6/2020 - 1/4/2021 signed and dated by physician D on 11/23/2020 which indicated the patient's tracheostomy (a surgically created hole in the neck and into the airway to assist with breathing) cuff should be inflated between 2.3 ml (milliliters) to 2.7 ml while the patient is asleep. Review of an agency document titled "Physician Order Form" dated 12/17/2020 signed by physician C indicated the patient's tracheostomy cuff was to be inflated up to 3 ml at night as as needed for comfort. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 1/5/2021 - 3/5/2021 indicated the patient's tracheostomy cuff should be inflated between 2.3 ml to 3.0 ml while the patient is asleep. Under the subtitled section "60 Day Summary", the document indicated there were no changes to the patient's plan of care. Review failed to evidence the clinical record was accurate in regards to the changes in the plan of care. During an interview on 1/14/2021 at 12:53 p.m., the alternate administrator indicated the inaccurate documentation regarding no changes to the plan of care was her mistake. Review of an agency document titled "Coordination of Care Documentation" completed by employee A, registered nurse, failed to	{N 610}		

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{N 610}	Continued From page 37	{N 610}		

evidence a date. Under a subtitle "PDN [Private Duty Nursing]", the document stated, "... [patient's] trach [tracheostomy] ...." and failed to complete the statement. Review failed to evidence the clinical record was complete.

4. Clinical record review for patient #2 on 1/15/2021 at 10:43 a.m. of an unsigned and undated document the alternate administrator provided titled "Coordination of Care Documentation" failed to evidence a date and clinician's signature and title. Under a subtitle "PDN", the document stated, "... Visit was done virtually with ...." and failed to complete the statement. Review failed to evidence the clinical record was complete.

5. Clinical record review for patient #3 on 1/14/2021 evidenced an unsigned and undated agency document titled "Coordination of Care Documentation" which failed to evidence a date and clinician's signature and title. Under subtitle "PDN", the document stated, "... [patient] is resting in her wheelchair while receiving gtube [a surgically inserted tube into the stomach through the abdomen to administer nutrition, fluid and medication] bolus feeding during ...." and failed to complete the statement. Review failed to evidence the clinical record was complete.

6. During an interview on 1/14/2021 at 12:35 p.m., the alternate administrator indicated the clinical record documentation was to be maintained in the hard chart in the office or in the electronic health record.

7. During an interview on 1/15/2020 at 10:43 a.m., the alternate administrator indicated the process for completing the coordination of care document was to complete the form on her

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{N 610}	Continued From page 38 computer as a pdf (portable document format) file and then print and fax the form. The alternate administrator indicated the form does not print out in its entirety as it was written on her computer but rather prints a partial summary and not as it was written.	{N 610}		