STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 20125 to <u>-</u>		R
		012050	B. WING		01/15/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE	
AVEANNA	HEALTHCARE		OSEVELT RD, S	UITE 200-1	
	OUNDAL DV OT		AISO, IN 46383	DD0//DDD0 D/ AV 05 00DD5 07/0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPER DEFICIENCY)	BE COMPLETE
{N 000}	Initial Comments		{N 000}		
	Control and complain	t for a Focused Infection t survey of a home health 19/2020 - 8/21/2020 and ).			
	Survey dates: 1/12/20	021 - 1/15/2021			
	Facility Number: IN01	2050			
	04/14/21 Tag 9999 fro	om 01/15/21 survey deleted.			
N 440	410 IAC 17-12-1(a) H administration/manag		N 440		
	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.				
	failed to ensure the or	t as evidenced by: ew and interview, the agency ganization and lines of lation of responsibility were			
	The findings include:				
	titled "Location Manag	pany are to be under the strator These			
		document titled "Aveanna ional Chart" indicated the			

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMI LETED	
		012050	B. WING		R 01/15/2021	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE. ZIP CODE	1 01/10/2021	
			SEVELT RD, SI			
AVEANNA	HEALTHCARE	VALPARAI	SO, IN 46383			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPL	LETE
N 440	Continued From page	e 1	N 440			
	Administrator were lo within the organizatio to evidence the altern to the administrator.	ministrator and Alternate cated at the same position nal structure. Review failed ate administrator reported the entrance conference a.m., the alternate				
		d the alternate administrator				
{N 444}	410 IAC 17-12-1(c)(1 administration/manag		{N 444}			
	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 me Based on record revie administrator failed to day-to-day operations	ew and interview, the be responsible for all				
	The findings include:					
	titled "Scope of Service	policy revised 7/16/2020, ces" stated, " It is the y to provide services to				

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 2 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					F	₹
		012050	B. WING		01/1	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AVEANNA	HEALTHCARE		SEVELT RD, SI SO, IN 46383	UITE 200-1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{N 444}	that can by safely and patient's / client's / legalternate care setting service includes provide the following: Nursing (Home and Clinic Bast Occupational Therapy Work Home Health Review of an agency titled "Location Manageration of the Comparited "Location Manageration of an Adminication Director or A responsibility is organd day-to-day operations Administrator is to operation of the location Administrator The responsibilities including ongoing functions ensure compliance we accrediting body stan state, and federal law Employing qualified sof staff with active/cur and personnel files Review of an agency titled "Welcome to Ave" We strive to provide healthcare needs of employees encompassincluding Nurses, Hor Nursing Assistants, Pand Physical, Occupation Therapists"	e condition requires services deffectively rendered in the gal guardians home or other The Company's scope of sion and maintenance of Services Rehab Therapy sed) Physical Therapy, Social Aide"  policy revised 1/133/2020, gement" stated, " All pany are to be under the strator (also known as area Director) whose primary sization and direction of s. A qualified Alternate assume responsibility for the on in the absence of an Location Director's e: Organizing and directing Taking appropriate action to ith Aveanna policies, dards and applicable local, and regulation taff and ensuring utilization rent licenses, credentials ."  document revised 9/21/19, eanna Healthcare" stated, de services that cover the every patient, and our sa a variety of clinical roles me Health Aides, Certified ersonal Care Assistants,	{N 444}			

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 3 of 39

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or dorace more	IDENTIFICATION NOMBER.	A. BUILDING: _		
		012050	B. WING		R 01/15/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
۸\/E ۸ N N A	HEALTHCARE	2600 ROO	SEVELT RD, SI	JITE 200-1	
AVEARINA	TIEAETHOARE	VALPARAI	SO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{N 444}	Continued From page	e 3	{N 444}		
	provided skilled nursing services. The alternation contracted services with the provided prov	or did not have access to the 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.				
	the alternate administ was the acting admin administrator while or really the alternate ac oversee the personne employee C. The alte indicated her job was	n 1/14/2021 at 1:58 p.m., trator indicated although she istrator in absence of the medical leave, she was alministrator and did not el records and was the job of trate administrator more clinical and she did e electronic personnel			
{N 486}	410 IAC 17-12-2(h) Cimprovement	A and performance	{N 486}		
		e home health agency shall s with other health or social ving the patient.			
		t as evidenced by: ew and interview, the home to coordinate care with other			

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 4 of 39

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		012050	B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	: ZIP CODE	1 01	/15/2021
			OSEVELT RD, SUI			
AVEANNA	AHEALTHCARE		AISO, IN 46383			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
{N 486}	Continued From page	<del>2</del> 4	{N 486}			
	services, in a total sal reviewed. (#1, #2, #3	ved receiving skilled nursing mple of 4 clinical records				
	The findings include:					
	titled "Coordination of communication will be patients and all providuality the responsibility of telephone conference contact and other condocumented in the pathe responsibility of document the existen and services in order coordination of care at 2. Clinical record reviducument, the alternation as the skilled nurse vielectronically signed 12/18/2020 stated, " lessons with speech to	es, written notes, personal nmunication which are to be atient's medical record. It is exaction staff to identify and ce of other providers of care to assure appropriate and services"  ew for patient #1 on an untitled agency ate administrator identified				
	the alternate administ	n 1/14/2021 at 12:28 p.m., trator indicated there was no ne clinical record with the				
	1					

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 5 of 39

A. BUILDING: R  012050 B. WING 01/15/2021  NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	AND PLAN (	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SUR	
012050 B. WING 01/15/2021	7.1.1.2.1.2.1.1.1			A. BUILDING: _			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			012050	B. WING		1	2021
	NAME OF PI	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
AVEANNA HEALTHCARE 2600 ROOSEVELT RD, SUITE 200-1 VALPARAISO, IN 46383	AVEANNA	IA HEALTHCARE			JITE 200-1		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETE DATE
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 patients 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.	{N 486}	electronically signed in 12/18/2020, which incomplete speech and physical review failed to evide between the home heroviding speech and During an interview of the alternate administicate coordination with speech and physical reason as she has not had the Review of an unsigned the alternate administicate at 10:43 a.m. titled "On Documentation" indicespeech and physical failed to evidence any entity E.  During an interview of the alternate administicated to evidence any entity E.  During an interview of the alternate administication form was copy of the patient's proposed with anyone at and frequency of service.  4. Clinical record revices a skilled nurse visitant signed by the region indicated the patient of the representation between the response of the patient of the region and entity F.	by the registered nurse on dicated the patient received therapy from entity E. ence coordination of care ealth agency and the agency of physical therapy.  In 1/15/2021 at 10:36 a.m., trator indicated there was no in the agency providing therapy in the clinical recordine time.  In additional recording therapy in the clinical recordination of Care eated the patient received therapy from entity E, but by coordination of care with a plan of care, but did not a entity E to confirm the type vices provided to the patient.  In an untitled agency are administrator identified it note, dated 12/16/2020, gistered nurse, which was receiving physical and Review failed to evidence ween the home health	{N 486}			

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 6 of 39

Illulalia C	tate Department of He	ailii				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					_	
			B. WING		R	
		012050	B. WING		01/1	5/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		2600 ROC	SEVELT RD, S	HITE 200-1		
AVEANNA	HEALTHCARE		ISO, IN 46383	5112 200 1		
			130, 114 40303	T		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
		,		DEFICIENCY)		
{N 486}	Continued From page	e 6	{N 486}			
	revealed nerson .l at a	entity F had indicated the				
		ical therapy which began in				
	June of 2019.	ioai aioiapy milon bogaii iii				
	duric of 2010.					
	During an interview of	n 1/15/2021 at 11:12 a.m.,				
	-	trator indicated there was no				
		n 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.						
	inioniation the agone	y wedia want to obtain.				
N 504	410 IAC 17-12-3(b)(2	)(D)(i) Patient Rights	N 504			
		ent has the right to exercise				
	_	patient of the home health				
	agency as follows:					
		the right to the following:				
	` '	out the care to be furnished,				
	•	n the care to be furnished as				
	follows:					
	• •	agency shall advise the				
	patient in advance of					
	(AA) disciplines that					
	(BB) frequency of vis	sits proposed to be				
	furnished.					
	TI: DUI E :					
	This RULE is not me				ĺ	
		ew and interview, the agency				
		atient / caregiver consented				
		nges in the frequency of			ĺ	
	services that were be				ľ	
		ved receiving skilled nursing				
		mple of 4 records reviewed.			ĺ	
	(#2)					
	The findings include:					
	Review of an agency	document revised 7/30/19,				

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 7 of 39

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		012050	B. WING		R 01/15/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
AVEANNA	HEALTHCARE		SEVELT RD, SI ISO, IN 46383	UITE 200-1	
	CUMMADVCT		1	PROVIDENCE DI ANI OF CORRECTIO	DN
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
N 504	Continued From page	e 7	N 504		
	titled "Patient Rights a" As a patient, mem significant other, you in any prior payment to the patient orally an possible in advance of To expect continuit orally and in writing of possible in advance of provided"  Review of an agency titled "General Common communications with families, staff, physici	and Responsibilities" stated, where of a patient's family, or have the right: Changes information should be given and in writing as soon as of the next service provided. By of care To be informed from any changes as soon as of the next service.  I document revised 11/6/17, munication" stated, " Any patients, care-givers, ans, 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,				
		killed nurse was to provide hours a day, 5-7 days a			
	were provided at least weeks of 12/20/2020,	ence skilled nursing services at 5 days a week during the 12/27/2020 and 1/3/2021 rs a day on 12/23/2020 as f care.			
	Service Agreement" s patient's parent on 2/2 patient was to receive nursing services. Rev	document titled "Patient signed and dated by the 27/2020, indicated the 60 hours a week of skilled view failed to evidence the ented in advance to the			

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 8 of 39

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
					R	
		012050	B. WING		01	/15/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE		
AVEANNA	HEALTHCARE		OSEVELT RD, SU AISO, IN 46383	ITE 200-1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
N 504	the alternate administ nursing services were the plan of care due t alternate administrate had to adjust her sche when school started. administrator indicate	of the skilled nursing  n 1/15/2021 at 11:02 a.m., trator indicated the skilled to not provided as ordered in to staffing issues. The train indicated the skilled nurse train indicated the skilled nurse train indicated the end of summer at 11:02 a.m., the alternate d there was no tient's parent was notified of	N 504			
{N 522}	written medical plan of periodically reviewed chiropractor, optomet	edical care shall follow a of care established and by the physician, dentist, rist or podiatrist, as follows:	{N 522}			
	health agency failed the was followed in 3 of 3 with skilled nursing set 4 clinical records review. The findings include:  1. Review of an agentitled "Physician Orders services will be provided by services, as required by complete, individualized."	ew and interview, the home o ensure the plan of care clinical records reviewed ervices, in a total sample of				

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 9 of 39

PRINTED: 04/14/2021 FORM APPROVED

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		012050	B. WING		01	R I <b>/15/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE	,	
AVE ANNI	LIEALTHCADE	2600 RC	OSEVELT RD, SUI	TE 200-1		
AVEANNA	A HEALTHCARE	VALPAR	AISO, IN 46383			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{N 522}	regulations. The initial developed in conjunct physician/prescriber, Company's health cat admission process  2. Review of an agentitled "Cough Assist Mocumentation Date used Response/to effort Duration of the secretions Suction 3. Clinical record revitalization period 1.13/2021, evidence "Home Health Certificertification period 1.1/5/2021 - 3/5/2021, nurse was to provide via the g-tube (a surgestomach through the nutrition, fluid and momilliliters (ml) from 10 care also indicated the a straight urinary cat bladder through the uthe body) every 3-4 minimer a urinary foley the bladder and held balloon to drain urine collection bag) nightly gravity bag until 8 a.m.  Review of an untitled alternate administration urse visit note, election by the registered nur the nurse provided 1.	applicable law and state al Plan of Care/Treatment is ction with the patient/family and the are professional as part of the "  ancy policy revised 5/19/20, Machine" stated, " ate and time equipment is lerance to therapy Cough reatment Quality of sing, if appropriate"  iew for patient #1 on dagency documents titled cation and Plan of Care" for 1/6/2020 - 1/4/2021 and which indicated the skilled intermittent water flushes gically inserted tube into the abdomen to provide edication) totaling 150 of p.m. to 7 a.m. The plan of the skilled nurse was to insert the heter (a tube inserted into the urethra to drain urine from hours during the day and catheter (a tube inserted into in place with a small inflated at from the body into a y at 8 p.m. and connect to	{N 522}			

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 10 of 39

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		<b>\</b> '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			A. BOILDING.			5
		012050	B. WING		01	R / <b>/15/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
AVE A NIN /	A HEALTHCARE	2600 RO	OSEVELT RD, SUI	ΓE 200-1		
AVEAINIVA	RHEALIHOARE	VALPAR	AISO, IN 46383			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{N 522}	Continued From page	e 10	{N 522}			
		The review failed to rovided a total of 150 ml of g-tube as directed in the				
	the alternate administ	n 1/14/2021 at 12:42 p.m., trator indicated the plan of ed nurse to provide 150 ml ne patient's g-tube.				
	visit notes evidenced the foley catheter at 5 6:30 a.m. on 12/17/20 12/18/2020, 5:30 a.m on 12/22/2020, 5:30 a.m. on 12/24/2020, 5:30 a.m. on 12/31/20 5:30 a.m. on 1/4/2020 5:30 a.m. on 1/6/2020 5:30 a.m. on 1/8/2020 5:30 a.m. on 1/12/2020 1/15/2021. Record re	or identified as skilled nurse the skilled nurse removed 5:30 a.m. on 12/16/2020, 020, 5:30 a.m. on . on 12/21/2020, 5:30 a.m. a.m. on 12/23/2020, 5:30 5:30 a.m. on 12/29/2020, 020, 5:30 a.m. on 1/1/2021, 1, 5:30 a.m. on 1/5/2021, 1, 6:15 a.m. on 1/9/2021, 21 and 5:30 a.m. on view failed to evidence the 1 the plan of care to remove				
	visit notes, evidenced nurse, removed the p 12/17/2020 at 6:30 a. any urinary catheter price 8:16 a.m Employee failed to evidence the urinary straight cather on 12/17/2020. Recort the skilled nurse perfections.	ency documents, the or identified as skilled nurse I employee D, registered atient's foley catheter on m. and failed to evidence cation after the removal of or to the nurse's departure at E arrived at 9:00 a.m. and skilled nurse performed a terization prior to 11:15 a.m. or review failed to evidence formed urinary straight 3-4 hours as directed in the				

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 11 of 39

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
			7. BOILBING.		R	,
		012050	B. WING		1	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AVEANNA	HEALTHCARE		SEVELT RD, SI	UITE 200-1		
	I		SO, IN 46383			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{N 522}	Continued From page	<del>2</del> 11	{N 522}			
	plan of care.					
	the alternate administ nurse was to remove per the plan of care. A administrator indicate performed by the care documented by the a During an interview o employee B, licensed the skilled nurse did r	gency staff.  n 1/14/2021 at 12:25 p.m., practical nurse, indicated 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.					
	provided nursing care 12/17/2020, 12/18/20 12/21/2020, 12/29/20 12/28/2020, 12/29/20 1/1/2021 and 1/2/202 documents titled "Mer Record / Medication F 12/13/2020 - 12/19/20 12/26/2020 and 12/27 evidence the skilled market	or identified as skilled videnced the skilled nurse on 12/16/2020, 20, 12/19/2020, 12/20/2020, 20, 12/23/2020, 12/31/2020, 12/30/2020, 12/2020, 12/2020, 12/2020, 12/2020, 12/2020, 12/2020, 12/2020, 12/2020, 12/				

Indiana State Department of Health

STATE FORM 6899 3BO113 If continuation sheet 12 of 39

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		012050	B. WING		01/15/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
AVEANNA HEALTHCARE			SEVELT RD, SI SO, IN 46383	UITE 200-1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
{N 522}	Continued From page	÷ 12	{N 522}			
	alternate administrator why the medication a indicated the 3% Sod as discontinued and torder for the discontinued and torder for the discontinues was to initial the record if the medication.  4. Clinical record revirus 1/13/2021, evidenced "Home Care Certification period 12 signed and dated by the which indicated the slinursing services 8-16 week. The skilled nur assist treatments (a nuclear the airway wher airway secretions effectively breaths every 6 hours Review of untitled again alternate administrator visit notes, dated and skilled nurse on 12/30	ium Chloride was marked here was not a physician nuation of the medication. Strator indicated the skilled e medication administration on was administered.  ew for patient #2 on an agency document titled tion and Plan of Care" for 1/23/2020 - 2/20/2021, the physician on 12/24/2020, killed nurse was to provide thours a day, 5-7 days a se was to administer cough non-invasive treatment to a unable to cough or clear ectively) for 3 cycles of 5 and as needed.  ency documents, the or identified as skilled nurse electronically signed by the 10/2020, 1/4/2021, 1/8/2021 to evidence the skilled				
	the alternate administ nurse notes do not st provided the cough a alternate administrate should document the	n 1/15/2021 at 10:50 a.m., trator indicated the skilled ate if the skilled nurse				

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 13 of 39

NAME OF PROVIDER OR SUPPLIER  D12050  STREET ADDRESS, CITY, STATE, ZIP CODE  R 01/15/202		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE  A. BUILDING: _		(X3) DATE SURVEY COMPLETED
012000 01/13/202						R
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	012050			B. WING		01/15/2021
	NAME OF PR	PROVIDER OR SUPPLIER				
AVEANNA HEALTHCARE 2600 ROOSEVELT RD, SUITE 200-1 VALPARAISO, IN 46383	I AVEANNA HEALTHCARE			JITE 200-1		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COMPLETE
{N 522} Continued From page 13 {N 522}	{N 522}	Continued From page	e 13	{N 522}		
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/s/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.		were provided at leas weeks of 12/20/2020, and for at least 8 hour directed in the plan of During an interview of the alternate administ nursing services were the plan of care due to alternate administrato had to adjust her schewhen school started.  5. Clinical record revied 1/14/2021, evidenced "Home Care Certificate certification period 11, and dated by the physindicated the patient voursing services 8-10 week. Review failed to provided skilled nursing - 12/27/2020, as orde.  During an interview of employee B, licensed the agency should had to hold services that vordered.  During an interview of employee C, client se skilled nursing services skilled nursing services 12/18/2020 to 12/27/2	at 5 days a week during the 12/27/2020 and 1/3/2021, rs a day on 12/23/2020, as a care.  In 1/15/2021 at 11:02 a.m., trator indicated the skilled a not provided as ordered in staffing issues. The prindicated the skilled nurse edule at the end of summer and agency document titled tion and Plan of Care" for 1/5/2020 - 1/3/2021, signed sician on 11/20/2020, which was to receive skilled hours a day, 3-5 days a so evidence the agency ng services from 12/18/2020 ared in the plan of care.  In 1/15/2020 at 11:38 a.m., a practical nurse, indicated the obtained a verbal order were not being provided as a cevidence the supervisor, indicated the swere not provided from the provided from			

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 14 of 39

Indiana State Department of Health						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
	012050 B. WING				1	5/2021
		012030			01/1	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		2600 RO	OSEVELT RD, S	UITE 200-1		
AVEANNA	HEALTHCARE	VALPAR	AISO, IN 46383			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
				BEI IOIEI(CT)		
{N 524}	Continued From page	e 14	{N 524}			
(NL 524)	410 10 0 17 12 1(0)/1	\ Dationt Core	(N 524)			
{IN 324}	410 IAC 17-13-1(a)(1	) Patient Care	{N 524}			
	Rule 13 Sec 1(a)(1)	As follows, the medical plan				
	of care shall:	As follows, the medical plan				
		consultation with the home				
	health agency staff.	Serieulation with the nome				
		es to be provided if a skilled				
	service is being provi	•				
	(B) Cover all pertiner	nt diagnoses.				
	(C) Include the follow	ving:				
	(i) Mental status.					
	(ii) Types of service	es and equipment required.				
		duration of visits.				
	(iv) Prognosis.					
	(v) Rehabilitation p					
	(vi) Functional limit					
	(vii) Activities permit					
	(viii) Nutritional requi					
	(ix) Medications an					
		asures to protect against				
	injury. (xi) Instructions for	timely discharge or referral.				
		ties specifying length of				
	treatment.	ties specifying length of				
	(xiii) Any other appro	ppriate items.				
		•				
	This RULE is not me					
	Based on record revie	ew and interview, the home				
		to ensure the plan of care				
		contain medical supplies,				
		entions and goals and				
		clinical records reviewed.				
	(#1, #2, #3, #4)					
	The finaliness in the l					
	The findings include:					
	1 Poviou of an age-	ov policy roviced 0/40/40				
		cy policy revised 9/19/19,				
	i iided Physician Orde	ers" stated, " A complete,				

STATE FORM 6899 3BO113 If continuation sheet 15 of 39

PRINTED: 04/14/2021 FORM APPROVED

Indiana State Department of Health

NAME OF PROVIDER OR SUPPLIER  A. BUILDING:  B. WING  O1/15/20  NAME OF PROVIDER OR SUPPLIER  A. BUILDING:  R  O1/15/20  STREET ADDRESS, CITY, STATE, ZIP CODE  2600 ROOSEVELT RD, SUITE 200-1  VALPARAISO, IN 46383		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	
NAME OF PROVIDER OR SUPPLIER  AVEANNA HEALTHCARE  O12050  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  2600 ROOSEVELT RD, SUITE 200-1			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2600 ROOSEVELT RD, SUITE 200-1	012050		
AVEANNA HEALTHCARE 2600 ROOSEVELT RD, SUITE 200-1			
AVEANNA HEALTHCARE	SUPPLIER	NAME OF PRO	
VALPARAISO, IN 46383	ARF	AVFANNA H	
	VALP		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ACH DEFICIENCY	PREFIX	
{N 524} Continued From page 15 {N 524}	ed From page	{N 524}	
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 *1/5/2021 *which indicated the patient was 7 years old. The document indicated patient was 7 years old. The document indicated patient was 1 period years of years old. The document indicated patient was 1 period years of years old. The document indicated patient was 1 period years of years old. The document indicated patient was 1 period years of years old. The document indicated patient was 1 period years of years old. The document indicated patient was 1 period years of years old. The document indicated patient was 1 period years of years old. The document indicated patient was 1 period years of years old. The document indicated patient was 1 period years of years old. The document indicated patient was 1 period years of years	alized Plan of ed for all patie according to ans. The initial ed in conjunction/prescriber, py's health care on process eatment must le: Primary otion of any Trand/or specifications (including to be administed long and es that are related for long and es that are related long and established long and the patient was per minute. The the skilled not be the		

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 16 of 39

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R
012050			B. WING		01/15/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
AVFANN/	HEALTHCARE	2600 RO	OSEVELT RD, SU	JITE 200-1	
AVEARITY	TIEREITIOAKE	VALPARA	AISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
{N 524}	also included adminis and medications via ginserted tube into the abdomen to deliver not medications) and cleat wice daily. The plan opatient-specific goals catheterization and garcare.  Review of an untitled alternate administrate comprehensive assessed electronically signed to 1/4/2021 indicated the 50-120 beats per min respiration was 12-28. Review of a reference Vital Signs Normal Rahttps://medicine.uiowac-vital-signs-normal-range for the heart rafe 65-120 beats per min for the respiratory rate breaths per minute.  Review failed to evide to evidence the heart parameters were individed to evidence the heart parameters were individed to the patient's age.  During an interview of the patient's physician respiration parameters respiration parameters.	skilled nursing interventions tering the patient's nutrition gastrostomy (a surgically stomach through the utrition, fluids and aning the gastrostomy site of care failed to evidence related to the urinary astrostomy feedings and agency document the or identified as the sament dated and by the registered nurse on a range for pulse was ute and the range for breaths per minute.  A document titled "Pediatric anges" website a edu/iowaprotocols/pediatri anges indicated the normal te for a 7 year old was ute and the normal range are for a 7 year old was ute and the normal range are for a 7 year old was 15-30 ence the clinical record failed rate and respiration vidualized to meet the needs  an 1/14/2021 at 11:52 a.m., trator indicated the agency ent-specific directions from a related to the pulse and	{N 524}	DEFICIENCY)	
		ency of the catheter and			

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 17 of 39

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:	
		012050 B. WING			R 01/15/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE	
AVEANN	A HEALTHCARE		DSEVELT RD, SU AISO, IN 46383	JITE 200-1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
{N 524}	gastrostomy, balance abdomen free of disternate and respiration parameters for pulse no patient-specific parecord at the physician parameters for pulse no patient-specific parecord at the physician parameters for pulse no patient-specific parecord at the physician parameters for pulse no patient-specific parecord at the physician Review of an untitled alternate administrate nursing visit note date by the registered nursithe patient was weari. The plan of care faile supplies and medical hand splint.  During an interview of the alternate administrate administr	ed intake and output and ention.  14/2021 at 2:25 p.m. from an office related to the pulse neters revealed person B, obysician's office, indicated a did not determine the or respiration and there was trameters in the patient's an's office.  agency document the or identified as a skilled ed and electronically signed se on 1/8/2021 evidenced and a splint on the left hand. If to evidence the patient's equipment included the equipment included the on 1/14/2021 at 12:07 p.m., trator indicated the plan of the left hand splint but should an the patient's medical ficare.  ew for patient #2 on an agency document titled and electronically signed the plan of the patient's medical ficare.  ew for patient #2 on an agency document titled attion and Plan of Care" for 2/23/2020 - 2/20/2021 which was to receive CPT (chest way clearing technique to any a vest which performs by vest treatments every 6	{N 524}		

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 18 of 39

PRINTED: 04/14/2021 FORM APPROVED

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
012050			B. WING		0,	R I <b>/15/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
		2600 RC	OOSEVELT RD, SUI	ΓE 200-1		
AVEANNA	AHEALTHCARE	VALPAF	RAISO, IN 46383			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{N 524}	the alternate adminis gastrostomy tube fee apart and indicated the indicated the patient a.m., 12 p.m., 3 p.m. be included in the plate of the alternate administ indications for the CF congestion and thick be included in the plate of the included in the plate of the included	e feedings.  In 1/13/2021 at 3:15 p.m., strator indicated the edings should be spaced the skilled nurse in the home received tube feedings at 9 and 6 p.m. daily and should an of care.  In 1/15/2021 at 10:49 a.m., strator indicated the prn PT vest treatment were for ened secretions and should an of care.  Item for patient #3 on an agency document titled ation and Plan of Care" for 1/5/2020 - 1/3/2021 signed resician on 11/20/2020 which murse was to place the reatment that uses mild air airway open) via a nasal at indicated the patient's but was not limited to, sungal medication), which each as needed three times to evidence the plan of care include when the skilled the BiPAP treatment and for led to evidence the Plan of ed to include where the rash atted where the Nystatin	{N 524}			
	the alternate adminis	on 1/15/2021 at 11:33 a.m., trator indicated the plan of when the BiPAP was to be ould be removed. At 11:45				

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 19 of 39

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			SURVEY LETED
7.1.12 . 2.1.1	5. GG.W.EG.WG.	is a transfer to the state of t	A. BUILDING: _			
012050		B. WING		l l	R <b>15/2021</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
AVEANNA	HEALTHCARE		ISEVELT RD, SI ISO, IN 46383	UITE 200-1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{N 524}	was unsure where the applied.  Review of an agency Certification and Plan period 1/4/2021 - 3/4/ the provider on 12/30 nurse was to provide provide gastrostomy medications. Review of care was individua for the inflation of the During an interview of the alternate administicate did not specify the orders and she needed determine the amount was to be inflated with During an interview of employee B, licensed the orders for the inflation of the included in 5. Clinical record reving the orders for the inflation of the included in the orders for the inflation of the included in the orders for the inflation of the included in the orders for the inflation of the included in the orders for the inflation of the included in the orders for the inflation of the included in the orders for the inflation of the included in the orders for the inflation of the included in the orders for the inflation of the included in the orders for the inflation of the included in the orders for the inflation of the included in the orders for the inflation of the included in the include	document titled "Home Care of Care" for certification /2021 signed and dated by 1/2020 indicated the skilled gastrostomy care and tube feedings and failed to evidence the plan lized to include the orders gastrostomy tube.  In 1/15/2021 at 11:50 a.m., trator indicated the plan of the gastrostomy tube inflation ed to obtain an order to at of inflation and whether it h air or water.  In 1/15/2021 at 11:52 a.m., I practical nurse, indicated ation of the gastrostomy tube the plan of care.  Ew for patient #4 on a document from the sician titled "Progress Notes" the indicated the patient was shaler (to treat wheezing or as needed.  document titled "Home	{N 524}			
	During an interview o	n 1/13/2021 at 11:02 a.m.,				

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 20 of 39

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
74101244	or connection	ibertii ie, trieit treiibert.	A. BUILDING:				
		012050	B. WING		R   <b>01/1</b> :	5/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
AVEANNA	HEALTHCARE		SEVELT RD, SI SO, IN 46383	JITE 200-1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
{N 524}	Continued From page	<del>2</del> 20	{N 524}				
	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 527}	27} 410 IAC 17-13-1(a)(2) Patient Care		{N 527}				
	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.						
	health agency failed to physician to any chan condition or needs that are not being achieve should be altered in 1 skilled nursing services	ew and interview, the home o promptly alert the ages in the patient's at suggest that outcomes and that the plan of care of 3 records receiving es (#1) and in 1 of 1 record a aide services (#4) in a total					
	The findings include:						
	titled "Physician Orde must be promptly aler patient's condition or	cy policy revised 9/19/19 rs" stated, " The physician rted to any changes in the needs that suggest that ng achieved and/or the POC pe altered"					

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 21 of 39

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED
		012050	B. WING		0.	R I/ <b>15/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODE	1 0	1713/2021
TVAWLE OF T	NOVIDEN ON GOLT EIEN		OSEVELT RD, SUI			
AVEANNA	AHEALTHCARE		AISO, IN 46383			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{N 527}	Continued From page	21	{N 527}			
	"Home Health Certific certification period 11 and dated by physicia indicated the patient's created hole in the neassist with breathing) between 2.3 ml (millilipatient is asleep.  Review of an agency Order Form" dated 12 physician C indicated cuff was to be inflated needed for comfort. Fevidence the physicia care was notified of the cuff inflation orders from 1/6/2021 when the playeriod beginning 1/5/2 a time period greater.	an agency document titled ration and Plan of Care" for 1/6/2020 - 1/4/2021 signed an D on 11/23/2020 which a tracheostomy (a surgically reck and into the airway to cuff should be inflated riters) to 2.7 ml while the document titled "Physician 2/17/2020 signed by the patient's tracheostomy of up to 3 ml at night as as record review failed to an responsible for the plan of the change in tracheostomy om physician C prior to an of care for certification 2021 was signed which was than 2 weeks.				
		trator indicated the physician changes should be reported				
	dated 8/18/2020 which to continue her medic limited to, Lamictal (a seizures) daily and all wheezing or shortnes	a document from the sician titled "Progress Notes" th indicated the patient was eation including, but not medication to treat buterol inhaler (to treat s of breath) as needed.				

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 22 of 39

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2500 ROOSEVELT RD, SUITE 200-1  VALPARAISO, IN 48383  [AUTHOR OF PROVIDER OR SUPPLIER 2500 ROOSEVELT RD, SUITE 200-1  VALPARAISO, IN 48383  [AUTHOR OF PROVIDER PLAN OF CONNECTION MICROPART PLAN OF CONNECTION (EACH CONNECTION MICROPART PLAN OF CONNECTION MICROPART PL		F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  AVEANNA HEALTHCARE  STREET ADDRESS, CITY, STATE, ZIP CODE 2600 ROOSEVELT RD, SUITE 200-1 VALPARAISO, IN 46383   [X4) ID PREPIX TAG  SUMMARY STATEMENT OF DEFICIENCYS TAG  ID PROVIDER'S PLAN OF CORRECTION (EACH DEPICENCY MUST BE PRECEDED BY FULL TAG  (N 527)  Continued From page 22 (N 527)  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 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 medications included Lamictal.  During an interview at the patient's home on 1/1/3/2021 at 8:08 a.m., the legal guardian indicated the physician ordered a new seizure 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.	012050		B. WING		<b>I</b>	2021	
SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   PROVIDERS PLAN OF CORRECTION (COMPLETE TAG   PROVIDERS PLAN OF COMPLETE TAG   PROV			2600 ROOS	SEVELT RD, SI		,	
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 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 gother 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.	PREFIX	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	COMPLETE
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	{N 527}	certification period 12 and dated by the physical the patient was 14 yeincluded, but were not disorder that causes seizures, cerebral pall hyperactivity disorder patient was to receive 5-7 days a week and notify the supervising patient's status. The pincluded, but were not medication to treat At Disorder) daily. The pevidence the patient's Lamictal.  During an interview a 1/13/2021 at 8:08 a.m guardian indicated shipatient's medications insurance so the patient medications. At 11:02 indicated the physicial medication, which not she has not picked up pharmacy. The legal patient has not been she could not afford the covered by the patient Review failed to evide communicated with the not taking Guanfacine or requested a medic covered by the patient During an interview of the patient patient and interview of the patient patient patient has not picked up pharmacy. The legal patient has not been she could not afford the covered by the patient	c/3/2020 - 2/2/2021 signed sician on 1/7/2021 indicated ars old and diagnoses at limited to, epilepsy (a seizures), post traumatic sy and attention deficit. Review evidenced the experience home health aide services the home health aide was to nurse for all changes in the patient's medications at limited to, Guanfacine (a tention Deficit Hyperactivity plan of care failed to a medication included at the patient's legal le could not afford the not covered by the ent has gone without those at a.m., the legal guardian an ordered a new seizure me she could not recall, so the medication at the guardian indicated the taking Guanfacine because the medication as it was not at's insurance.  The patient's legal to see the agency the physician the patient was a and Lamictal as prescribed ation change that would be at's insurance.  The 1/15/2021 at 11:59 a.m.,	{N 527}			

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 23 of 39

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  012050		(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED
			B. WING		0.1	R / <b>15/2021</b>
					1 01	/15/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
AVEANNA	A HEALTHCARE		OSEVELT RD, SUI	TE 200-1		
	VALPAR					T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
{N 527}	Continued From page	23	{N 527}			
	services to the patien should have notified to patient was not taking Lamictal. At 12:26 p.r administrator indicate been notified the patient and Guanfacine.	ed the patient's legal the home health aide providing the home health aide the supervising nurse the the Guanfacine and the alternate that the physician had not the man and the physician had not the man and the physician had not the physician				
{N 537}	410 IAC 17-14-1(a) S	cope of Services	{N 537}			
	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:					
	of care in 2 of 3 recor skilled nursing service	ew and interview, the				
	The findings include:					
	titled "Physician Orde services will be provide	cy policy revised 9/19/19 ers" stated, " Care and ded in accordance with authorized individual's) y law and regulation.				
	titled "Skilled Profess	cy policy revised 9/21/2020 ional Services" stated, " ervices are provided by a				

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 24 of 39

PRINTED: 04/14/2021 FORM APPROVED

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R
		012050	B. WING		01/15/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
AVEANNA	HEALTHCARE		SEVELT RD, SI	JITE 200-1	
			SO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{N 537}	supervision of a Registaccordance with a medicare/Treatment All participate in all aspervices that physician as indicated.  3. Review of an agent titled "Cough Assist M Documentation Daused Response/toleffort Duration of treatments Suctioni.  4. Clinical record revied. 1/13/2021 evidenced. "Home Health Certific certification period 11. 1/5/2021 - 3/5/2021 with a series was to provide via the g-tube (a surgestomach through the sum trition, fluid and memilliliters (ml) from 10 care also indicated the aurinary foley cathete bladder and held in please.	a Licensed Practical tional Nurse under the stered Nurse and in edically approved Plan of skilled professionals are to cts of care including: at are ordered by the d in the plan of care"  cy policy revised 5/19/20 Machine" stated, " te and time equipment is erance to therapy Cough eatment Quality of ng, if appropriate"  ew for patient #1 on agency documents titled eation and Plan of Care" for /6/2020 - 1/4/2021 and which indicated the skilled intermittent water flushes ically inserted tube into the abdomen to provide edication) totaling 150 p.m. to 7 a.m. The plan of e skilled nurse was to insert er (a tube inserted into the lace with a small inflated	{N 537}		
	gravity bag until 8 a.m  Review of an untitled alternate administrato nurse visit note electr	at 8 p.m. and connect to n agency document the or identified as a skilled onically signed and dated by			
	nurse provided 170 m	on 12/22/2020 evidenced the oil of water flushes via the oil p.m. on 12/21/2020 to 5:30			

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 25 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLE	
		012050	B. WING		R 01/1	5/2021
	ROVIDER OR SUPPLIER	2600 ROC	DRESS, CITY, STA SEVELT RD, SI ISO, IN 46383	•	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{N 537}	evidence the registered 150 ml of water flushed in the plan of care.  During an interview of the alternate administrate ad	ed nurse provided a total of es via the g-tube as directed in 1/14/2021 at 12:42 p.m., trator indicated the plan of ed nurse to provide 150 ml ne patient's g-tube.  ency documents the or identified as skilled nurse the registered nurse the ter at 5:30 a.m. on . on 12/17/2020, 5:30 a.m. a.m. on 12/21/2020, 5:30 a.m. on . on 12/31/2020, 5:30 a.m. on . on 12/31/2020, 5:30 a.m. on . on 1/4/2021, 5:30 a.m. on n 1/6/2021, 5:30 a.m. on n 1/8/2021, 5:30 a.m. on n 1/8/2021, 5:30 a.m. on n 1/15/2021. Recordince the skilled nurse are to remove the foley directed.  In 1/14/2021 at 12:12 p.m., trator indicated the skilled the foley catheter at 8 a.m.  In document titled "Home if Plan of Care" for /6/2020 - 1/4/2020 signed	{N 537}			

Indiana State Department of Health

used to produce sputum to increase lung

STATE FORM 8899 3BO113 If continuation sheet 26 of 39

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING:   COMPLETED	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	
	01 001111201	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	PROVIDER OR	
AVEANNA HEALTHCARE 2600 ROOSEVELT RD, SUITE 200-1 VALPARAISO, IN 46383	A HEALTHC	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	,	
(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, 12/21/2020, 12/21/2020, 12/21/2020, 12/21/2020, 12/21/2020, 12/22/2020, 12/23/2020, 12/28/2020, 12/20/2020 and 12/31/2020, Review of agency documents titled "Medication Profile" dated for the weeks 12/13/2020 - 12/19/2020 - 12/20/2020 - 12/26/2020 and 12/27/2020 - 12/202020 and 12/27/2020 in the plan of care.  During an interview on 1/14/2021 12:56 p.m., the alternate administrator indicated the 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 administration record if the medication was administration record if the medication 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 administrator indicated the skilled nurse was to administration record in the medication 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	function) Review of alternate nursing of provided 12/17/20 12/22/20 and 12/3 titled "Medication 12/13/20 evidence Sodium of During an alternate why the mindicated as disconforder for The alternurse is record if 5. Clinica 1/13/202 "Home of Certification and date indicated services skilled nutreatment airway where the services is skilled nutreatment.	

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 27 of 39

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE S COMPLE	
					R	
		012050	B. WING		1	5/2021
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AVEANNA	HEALTHCARE		SEVELT RD, SI SO, IN 46383	JITE 200-1		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETE DATE
{N 537}	Continued From page	27	{N 537}			
	visit notes dated and registered nurse on 1 1/8/2021 and 1/11/20	21 failed to evidence the I cough assist treatments as				
	the alternate administ nurse notes do not sta provided the cough as alternate administrato should document the	or indicated the skilled nurse cough assist treatment was and indicate the number of				
{N 542}	410 IAC 17-14-1(a)(1	)(C) Scope of Services	{N 542}			
	are limited to therapy	nealth setting, the registered owing:				
	to reflect current healin 2 of 3 records revie					
	The findings include:					
	titled "Physician Orde	cy policy revised 9/19/19 rs" stated, " A complete, Care/Treatment will be ents receiving clinical				

Indiana State Department of Health

STATE FORM 6899 If continuation sheet 28 of 39 3BO113

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
			B WING		1	₹
		012050	B. WING		01/1	15/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
AVEANNA	A HEALTHCARE		OSEVELT RD, SU	UITE 200-1		
	CUMMADVCT		AISO, IN 46383	DDOWDEDIS DI AN OF CODDECT	ION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{N 542}	Continued From page	e 28	{N 542}			
	regulations The Pl be reviewed and revis patient's condition or	·				
	"Home Health Certific certification period 11 and dated by physicia indicated the patient's created hole in the ne assist with breathing)	an agency document titled cation and Plan of Care" for 1/6/2020 - 1/4/2021 signed an D on 11/23/2020 which is tracheostomy (a surgically eck and into the airway to cuff should be inflated iters) to 2.7 ml while the				
	Order Form" dated 12 physician C indicated	document titled "Physician 2/17/2020 signed by the patient's tracheostomy d up to 3 ml at night as as				
	Order Form" dated 12 physician indicated ga	document titled "Physician 2/21/2020 and signed by the auze to be used at the d changed as needed.				
	was revised to reflect	to evidence the plan of care the order for the gauze at and the change in the				
	the alternate administ	n 1/14/2021 at 12:51 p.m., trator indicated the plan of period ending 1/4/2021 was				
		ew for patient #2 on an agency document titled cation and Plan of Care" for				

Indiana State Department of Health

STATE FORM 8899 3BO113 If continuation sheet 29 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
,			A. BUILDING:			
		012050	B. WING		F   01/1	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AVEANNA	HEALTHCARE		SEVELT RD, SI SO, IN 46383	JITE 200-1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{N 542}	indicated the skilled in Mickey button (a type is surgically inserted in abdomen for the administrated in and medication) 12 F used to measure the tubes), 1.5 cm (centing Review of an agency Order Form" dated 1/ physician indicated the changed to 12 Fr 1.7  Record review failed was revised to reflect button size.  During an interview of the alternate administrated in surgical statement of the skilled in the statement of the skilled in th	/23/20020 - 2/20/2021 nurse was to maintain the of gastrostomy tube which nto the stomach through the inistration of nutrition, fluid or (french gauge system size of a gastrostomy neter).  document titled "Physician 8/2021 and signed by the ne Mickey button size was	{N 542}			
N 558	Rule 14 Sec. 1(a) (2)(in the home health se nurse shall do the foll (F) Accept and carry chiropractor, podiatris and written).  This RULE is not me Based on record reviel licensed practical nur ordered by the physic of care in 1 of 1 recornursing services from	out physician, dentist, st, or optometrist orders (oral t as evidenced by:	N 558			

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 30 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		, ,	X3) DATE SURVEY COMPLETED	
		012050	B. WING		01	R / <b>15/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	, ,	710/2021
			OSEVELT RD, SUI			
AVEANNA	HEALTHCARE		AISO, IN 46383			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 558	Continued From page	e 30	N 558			
	(#1)					
	The findings include:					
	"Physician Orders" st will be provided in acc other authorized indiv by law and regulation Review of an agency titled "Skilled Profess Skilled professional s Registered Nurse or a Nurse/Licensed Voca supervision of a Regi accordance with a me Care/Treatment All participate in all aspe Providing services tha	policy revised 9/21/2020 ional Services" stated, " ervices are provided by a a Licensed Practical tional Nurse under the stered Nurse and in edically approved Plan of skilled professionals are to cts of care including:				
	evidenced agency do Certification and Plan period 11/6/2020 - 1/4 3/5/2021 which indica insert a straight urina into the bladder throu from the body) every and insert a urinary for into the bladder and h inflated balloon to dra	ated the skilled nurse was to ry catheter (a tube inserted gh the urethra to drain urine 3-4 hours during the day bley catheter (a tube inserted neld in place with a small hin urine from the body into a y at 8 p.m. and connect to				
	visit notes evidenced	ency documents the or identified as skilled nurse the licensed nurse removed 6:15 a.m. on 1/9/2021.				

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 31 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		012050	B. WING		01/15/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
AVE ANN A	HEALTHCARE	2600 ROOS	SEVELT RD, SI	UITE 200-1	
AVEANNA	TILALITICANE	VALPARAI	SO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 558	Continued From page	31	N 558		
		to evidence the licensed an of care to remove the n. as directed.			
	visit notes evidenced nurse, removed the p 12/17/2020 at 6:30 a. any urinary catheteriz the foley catheter price 8:16 a.m Employee arrived at 9:00 a.m. a licensed practical nurstraight catheterizatio 12/17/2020. Record reskilled nurse performe	employee D, registered atient's foley catheter on m. and failed to evidence ration after the removal of or to the nurse's departure at E, licensed practical nurse, and failed to evidence the se performed a urinary on prior to 11:15 a.m. on eview failed to evidence the			
	the alternate administ	n 1/14/2021 at 12:12 p.m., trator indicated the skilled the foley catheter at 8 a.m.			
	employee B, licensed	n 1/14/2021 at 12:25 p.m., practical nurse, indicated not follow the plan of care to it every 3-4 hours.			
	Care Certification and certification period 11 and dated by the physindicated the skilled n services 12-24 hours The patient's medicat	/6/2020 - 1/4/2020 signed sician on 11/23/2020 hurse was to provide nursing a day, 5-7 days a week. ion included, but was not a Chloride (a medication um to increase lung			

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 32 of 39

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R
		012050	B. WING		01/15/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
AVEANNA	HEALTHCARE		OSEVELT RD, SU AISO, IN 46383	JITE 200-1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
N 558	Continued From page	: 32	N 558		
	12/22/2020, 12/23/202 12/30/2020, 12/31/202 Review of agency doo Administration Record for the weeks 12/13/2 12/20/2020 - 12/26/20 1/2/2021 failed to evic nurse administered 30 directed in the plan of	r identified as skilled denced the licensed ed nursing care on 20, 12/19/2020, 12/21/2020, 20, 12/24/2020, 12/29/2021, 20, 11/2021 and 1/2/2021. Cuments titled "Medication do / Medication Profile" dated 1020 - 12/19/2020, 12/20 and 12/27/2020 - 12/2020 dence the licensed practical Medication Chloride as foare.			
	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 608}	pertinent past and cur with accepted profess maintained for every p (1) The medical plan identifying information (2) Name of the phy podiatrist, or optometr (3) Drug, dietary, tre (4) Signed and date	nical records containing rrent findings in accordance cional standards shall be coatient as follows: n of care and appropriate n. rsician, dentist, chiropractor,	{N 608}		

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 33 of 39

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		012050	B. WING		01	R I <b>/15/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ΔVFΔNNΔ	A HEALTHCARE	2600 RO	OSEVELT RD, SUI	ΓE 200-1		
AVEAINIV	TILALITICANL	VALPAR	AISO, IN 46383			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{N 608}	person responsible for the patient's care.  (6) A discharge sur This RULE is not me Based on record revifailed to ensure the colinical notes in 1 of 3 skilled nursing servicionical records review The findings include:  Review of an agency titled "Documentation documentation related of the permanent recipaper or electronic and other associated written at the time the incorporated into the regulation. All electrocaptured and submitted alternate administrate comprehensive asse electronically signed 12/18/2020 which incorporated to evid with the agency proving the patients.	rvice is rendered and purteen (14) days. harry reports sent to the or the medical component of nimary.  It as evidenced by: ew and interview, the agency linical record included all B records reviewed with es in a total sample of 4 wed. (#2)  I policy revised 11/3/2020 a Standards" stated, " All dt ocare is to become part ord Documentation is via Clinical paper progress paper notes are to be exervice is rendered and clinical record per state nic documentation is ited at the point of care"  If for patient #2 on 1/13/2021 agency document the or identified as the	{N 608}	DEFICIENC	CY)	
	with the agency prov therapy.					

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 34 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		012050	B. WING		0.	R I/ <b>15/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
AV/E A NINI	LIEALTUCADE	2600 RO	OSEVELT RD, SUI	ΓE 200-1		
AVEANNA	AHEALTHCARE	VALPAR	AISO, IN 46383			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{N 608}	not care coordination the agency providing in the clinical record at the alternation of the alternation of the alternation of the alternate administration of the last medication results and the last medication results and the last medication of the last medication provides p.m. titled "Medication alternate administration of the last medication profile patient's home and in the last medication profile patient's home and in the last medication profile patient of the last medication profile patient's home and in the last medication profile patient and the last medication profile patient's home and in the last medication profile patien	trator indicated there was in the clinical record with speech and physical therapy as she has not had the time.  If an unsigned and undated ate administrator provided on .m. titled "Coordination of ".  In 1/15/2021 at 10:43 a.m., strator indicated the care and was found in her folder the clinical record.  In the patient's viewed since 10/23/2020.  In the patient's are administrator verified eview was completed on a medication profile was	{N 608}			
		n was to be maintained in office or in the electronic				

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 35 of 39

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R
		012050	B. WING		01/15/2021
	ROVIDER OR SUPPLIER	2600 RO	DDRESS, CITY, STA OSEVELT RD, SI AISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
{N 608}	Continued From page	35	{N 608}		
	health record.				
{N 610}	410 IAC 17-15-1(a)(7	) Clinical Records	{N 610}		
	by: Based on record reviewhealth agency failed to clinical record were acappropriately authentiand title, dated and tirreviewed with skilled in	is not met as evidenced  ew and interview, the home of ensure all entries in the occurate, complete and cated to include a signature med in 3 of 3 records nursing services in a total cords reviewed. (#1, #2, #3)			
	The findings include:				
	titled "Documentation person who makes er entry by recording the of entry First and la Title. Standards for do follows, but not limited legible, complete, org and succinct Docu	cy policy revised 11/3/2020 Standards" stated, " Any atries will complete each of following: Date and time east name. Discipline and ocumentation are listed as at to: All entries are: anized, current, meaningful mentation must be detailed, care/services provided"			
	titled "Progress Sumn	documented progress s as per law and y reports as			

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 36 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 50.25		R	
		012050	B. WING		01/15/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
AVEANNA	HEALTHCARE		DSEVELT RD, SI NISO, IN 46383	UITE 200-1		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
{N 610}	limited to: Changes in Treatment Respon  3. Clinical record revital/13/2021 evidenced "Home Health Certific certification period 11 and dated by physicial indicated the patient's created hole in the neassist with breathing) between 2.3 ml (millil patient is asleep.  Review of an agency Order Form" dated 12 physician C indicated cuff was to be inflated uff was to be inflated needed for comfort.  Review of an agency Health Certification period 1/8 the patient's tracheos between 2.3 ml to 3.0 asleep. Under the sul Summary", the docur changes to the patient failed to evidence the in regards to the char During an interview of the alternate administinaccurate documentato the plan of care was Review of an agency	include but not necessarily a condition Outcome of se to care"  ew for patient #1 on an agency document titled cation and Plan of Care" for /6/2020 - 1/4/2021 signed an D on 11/23/2020 which is tracheostomy (a surgically eck and into the airway to cuff should be inflated iters) to 2.7 ml while the  document titled "Physician 2/17/2020 signed by the patient's tracheostomy drup to 3 ml at night as as  document titled "Home and Plan of Care" for 5/2021 - 3/5/2021 indicated stomy cuff should be inflated on ml while the patient is obtitled section "60 Day ment indicated there were no at clinical record was accurate ages in the plan of care.  In 1/14/2021 at 12:53 p.m., trator indicated the ation regarding no changes as her mistake.  document titled	{N 610}			
	"Coordination of Care by employee A, regis	e Documentation" completed tered nurse, failed to				

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 37 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D WING		R	
		012050	B. WING		01/1	5/2021
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
AVEANNA HEALTHCARE 2600 ROOSEVE VALPARAISO, II				JITE 200-1		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{N 610}	Duty Nursing]", the do [patient's] trach [trach complete the stateme evidence the clinical r  4. Clinical record reviral/15/2021 at 10:43 a. undated document the provided titled "Coord Documentation" failed clinician's signature a "PDN", the document virtually with" and statement. Review fair record was complete.  5. Clinical record reviral/14/2021 evidenced agency document titled Documentation" which and clinician's signature and clinician's signature and clinician's signature and clinician's signature and clinician's signature.  6. During in her wheeled surgically inserted tube the abdomen to admit medication] bolus fee complete the statement evidence the clinical record document in the hard electronic health record.  7. During an interview of the provided part of the	er a subtitle "PDN [Private ocument stated, " leostomy]" and failed to ent. Review failed to ecord was complete.  ew for patient #2 on each of an unsigned and ealternate administrator lination of Care do to evidence a date and not title. Under a subtitle stated, " Visit was done failed to complete the elied to evidence the clinical ew for patient #3 on an unsigned and undated ed "Coordination of Care the failed to evidence a date are and title. Under subtitle stated, " [patient] is mair while receiving gtube [a per into the stomach through enister nutrition, fluid and ding during" and failed to ent. Review failed to ecord was complete.  If on 1/14/2021 at 12:35 ministrator indicated the entation was to be do chart in the office or in the	{N 610}			
	process for completin	g the coordination of care nplete the form on her				

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 38 of 39

PRINTED: 04/14/2021 FORM APPROVED

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		012050	B. WING		R 01/15/202	21		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
AVEANNA HEALTHCARE 2600 ROOSEVELT RD, SUITE 200-1 VALPARAISO, IN 46383								
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COM	(X5) MPLETE DATE		
{N 610}	computer as a pdf (po and then print and fax administrator indicate in its entirety as it was	e 38  Ortable document format) file of the form. The alternate of the form does not print out is written on her computer trial summary and not as it	{N 610}					

Indiana State Department of Health

STATE FORM 3BO113 If continuation sheet 39 of 39